Indiana State Department of Health

LTC Newsletter

LTC & ICF/MR HOMES

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Rule Changes to Encompass New Requirements for Alzheimer's/ Dementia Care

On May 12, 2004, the Indiana State Department of Health Executive Board approved the final adoption of changes to 410 IAC 16.2 to include new requirements for in-service training on dementia care and requirements for the administration of Alzheimer's/ Dementia Care Special Unit (ADCSU). The Department anticipates the effective date of the rule to be late July to mid August 2004. Here are a few highlights of the major changes:

RULES

The following rules apply to both comprehensive and residential facilities.

1. Added to the rule is a definition for the word cognitive. "Cognitive means a person's ability for short and long term memory or recall; to make decisions regarding the tasks of daily living; and to make self understood.
2. The evaluation/assessment for admission to the facility must include an assessment of the resident's cognitive status.
3. All facilities must provide orientation, in-service education, and training programs that include the care of cognitively impaired residents.
4. Facilities required to submit an Alzheimer's and dementia care special unit disclosure form under IC 12-10-5.5 are required to:
   - Provide a copy of the disclosure form to the resident at the time of admission.
   - Designate a director for the ADCSCU.
5. The director must have:
   - An earned degree form an educational institution in a health care, mental health, or social service profession or be a licensed health facility administrator;
   - A minimum of one-year work experience with dementia or Alzheimer's residents, or both, within the past five years. A person serving as a director for an existing ADCSCU at the time of adoption of the rule (May 12, 2004) is exempt from the degree and experience requirements. However, he/she must meet the requirements for dementia specific training; and
   - A minimum of twelve hours of dementia specific training within three months of initial employment as the director of the ADCSCU, and six hours annually thereafter.
6. The director of the unit must:
   - Oversee the operation of the unit.
   - Ensure that personnel assigned to the unit receive the required in-service training
   - Ensure that the care provided to residents of the unit is consistent with in-service training, current practices for Alzheimer's and dementia care, and regulatory standards.
7. A. For comprehensive facilities, nursing staff must have twelve hours of in-service or training per year and non-nursing personnel must have six hours per year. IN ADDITION to these two requirements, ALL staff having regular contact with residents must have an additional six hours of dementia specific training within six months of initial employment (or within thirty days for personnel assigned to the ADCSCU) and three hours annually thereafter, to meet the needs, preferences, or both of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia.

B. For residential facilities, nursing staff must have eight hours of in-service or training per year and non-nursing personnel must have four hours per year. IN ADDITION to these two requirements, ALL staff having contact with residents must have an additional six hours of dementia specific

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training within six months of initial employment and three hours annually thereafter, to meet the needs, preferences, or both of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia.

GUIDELINES

The Indiana State Department of Health, Long Term Care Division (ISDH) has issued the following guidelines for implementation of the new rules.

1. All personnel may use training hours completed twenty-four months prior to the effective date of the rule to meet the training requirements. The training must be documented and specific to Alzheimer or dementia care.

2. For the Director of the ADCSCU, if hours completed within the past twenty-four months preceding the effective date of the rule are insufficient to meet the twelve-hour requirement, then additional hours must be completed within three months of the effective date of the rule.

3. For comprehensive staff assigned to the ADCSCU, if hours completed within the past twenty-four months preceding the effective date of the rule are insufficient to meet the six-hour requirement, then additional hours must be completed within thirty days of the effective date of the rule.

4. For comprehensive staff having regular contact with residents and residential staff and having contact with residents, if hours completed within the past twenty-four months preceding the effective date of the rule are insufficient to meet the six-hour requirement, then additional hours must be completed within six months of the effective date of the rule.

5. "Regular contact with residents…" and/or "…contact with residents" includes but is not limited to: nursing personnel, rehabilitation personnel, front office staff, activities staff, dietician, social service staff, and other personnel with resident contact. Examples of other personnel include but are not limited to:

A. Dietary staff who serve meals to residents;

B. Accounting staff meeting with or explaining billing to residents;

C. Janitorial staff that encounter residents while performing maintenance in resident's rooms or in corridors in which resident contact is likely;

D. Paid dining assistants (upon effective date of the Dining Assistant rule);

E. Medical Records staff with resident contact while on a resident unit.

6. All facilities must comply with all requirements of the rule six months following the effective date of the rule.

DEMENTIA CARE TRAINING COURSES

This Dementia Care Training Program (DCTP) develops and presents a series of educational programs relating to Alzheimer's disease and dementia related disorders. The program is sponsored by the Indiana State Department of Health (ISDH) and Alzheimer's Disease and Related Disorders Association of Greater Indiana, Inc. (Alzheimer's Association).

This educational program is designed for health care personnel working with residents diagnosed with Alzheimer's disease or related dementias. The program is designed with the intent of reducing deficient practices at long term care facilities and improving the quality of life and care for residents with Alzheimer's disease and related dementias living in Indiana long term care facilities.

The program will be funded by the ISDH civil money penalty (CMP) fund. The program consists of eight (8) educational courses that will be developed by the Alzheimer's Association. The Alzheimer's Association is responsible for the development, preparation, organization, planning, presentation, and evaluation of the Dementia Care Training Program. These courses will be presented multiple times in different locations.

DEMENTIA CARE TRAINING COURSES TO BE OFFERED

1. *Fundamentals of Dementia Care for Health Facility Personnel*

Course description: This course will be an eight-hour course for certified nurse aides and professional staff employed by health facilities. The course lays the foundation for understanding dementia care by exploring the background of dementia, diagnosis, stages of the disease, and treatment. Participants in the course will review and understand communication challenges, activities of daily living, challenging behaviors, and issues of being a caregiver for health facility residents with dementia. The course will discuss how the topic relates to the reduction of deficient practices of F-tags F497/F498.

2. *Problem Solving and Managing Behavior Issues in Dementia Care*

Course description: This course will be a minimum of three hours and is directed towards health facility personnel who have completed the "Fundamentals of Dementia Care for Health Facility Personnel" course as well as professional staff to include social workers, nurses, therapists, and administrators. The challenges of behaviors, both aggressive and non-aggressive, will be explained. Potential solutions and techniques will be presented with specific emphasis on topics such as combativeness, incontinence, sexuality, and wandering. Culturally sensitive approaches and working with the family are also examined. The course will discuss how the topic relates to the reduction of deficient practices of F-tags F224 and 226. The course will be presented twice in 2005. The courses will provide training for a total of 40 participants.

3. *Effective Communication in Dementia Care Course*

Course description: This course will be a minimum of three hours and is directed towards health facility personnel who have completed the "Fundamentals of Dementia Care for Health Facility Personnel" course as well as professional staff to include social workers, nurses, therapists, and administrators. Utilizing interactive training, this course provides the learner with information on verbal, non-verbal and written communication

techniques for persons with dementia. Special considerations involving cultural influences, hearing impairments, visual impairments, and documentation will be addressed. The course will discuss how the topic relates to the reduction of deficient practices of F-tags F240-246. The course will be presented twice in 2005. The courses will provide training for a total of 40 participants.

4. *Activities of Daily Living Course*

Course description: This course will be a minimum of three hours and is directed towards health facility personnel who have completed the "Fundamentals of Dementia Care for Health Facility Personnel" course as well as professional staff to include social workers, nurses, therapists, and administrators. This course will provide an advanced look at personal and daily care. Techniques for activities of daily living (bathing, dressing, eating, toileting, and ambulation) will be discussed. Using an interactive approach, this course provides participants opportunities to explore how daily living activities can become meaningful and incorporated into daily schedules. The course will discuss how the topic relates to a reduction of deficient practices of F-tags F309 and 310. The course will be presented twice in 2005. The courses will provide training for a total of 40 participants.

5. *Physical Health and Safety Course*

Course description: This course will be a minimum of three hours and is directed towards health facility personnel who have completed the Overview of Dementia for Health Facility Personnel Training Course as well as professional staff to include social workers, nurses, therapists, and administrators. This course explores classifications of medications and how to understand and identify adverse reactions. Nutrition and hydration is addressed as well as goal setting and identifying strategies for care giving when changes in eating behaviors occur. Effective care planning to include preventative measures for falls and wounds will be addressed. The course will discuss how dementia relates to F-tags F323 and 324. The course will be presented twice in 2005. The courses will provide training for a total of 40 participants.

6. *Managing Daily Activities Course*

Course description: This course will be a minimum of three hours and is directed towards health facility personnel who have completed the "Fundamentals of Dementia Care for Health Facility Personnel" course as well as professional staff to include social workers, nurses, therapists, and administrators. This course addresses the use of activities throughout the day that are individualized for those with dementia. Tips, techniques, and examples will be used to provide a meaningful exploration of the possibilities that activities provide in allowing residents to lead the fullest life possible. Individual and group activities as well as environmental design that facilitate activities will be emphasized. The course will discuss how the topic relates to a reduction of deficient practices of F-tags F240-246. The course will be presented twice in 2005. The courses will provide training for a total of 40 participants.

7. *Strategies for Creating Better Care Environments Course*

Course description: This course will be a minimum of three hours and is directed towards health facility personnel who have completed the "Fundamentals of Dementia Care for Health Facility Personnel" course as well as professional staff to include social workers, nurses, therapists, and administrators. The potential of the physical environment, both internal and external, to play an active role in shaping and supporting independence, stimulation, and quality of life for individuals with Alzheimer's disease and related dementias will be developed in this course. Special emphasis will be placed on principles behind design and the importance of utilizing the environment as a therapeutic tool. The course will discuss how the topic relates to the reduction of deficient practices of F-tags F323 and 324. The course will be presented twice in 2005. The courses will provide training for a total of 40 participants.

8. *Directing an Alzheimer's / Dementia Care Unit Course*

Course description: This will be a minimum of four hours and is directed towards health facility personnel identified as the director of a Alzheimer's / dementia care unit. The course will provide the participant with administrative practices and procedures for the operation of an Alzheimer's / dementia care unit. The course will instruct the participant on the training and in-service education of health facility personnel who work with Alzheimer's or dementia residents. The course will discuss regulatory standards relating to Alzheimer's / dementia care units and the reduction of deficient practices in providing dementia care.

<u>REQUIRED CONTENT OF ALL COURSES</u>

In addition to the specific criteria and description listed above for each specific program, all programs will include the following content:

1) A discussion of abuse and neglect of health facility residents as related to problems associated with Alzheimer's disease and other dementias. Each course will include a section on abuse and neglect as it relates to the specific topic of the course. The discussion will include suggestions as to best practices to prevent the abuse and neglect of health facility residents with regard to the specific course topic and emphasize reporting requirements and procedures for those persons witnessing abuse or neglect of health facility residents. The discussion will include how the course topic relates to reducing deficient practices of F-tags F223, 224, 225, and 226.

2) A discussion of the role of family members of the resident in addressing the quality of life and care of residents with Alzheimer's disease or dementia-related conditions with regard to the specific topic of the course. The discussion will include best practices as to communication between the facility and family members and how the course topic relates to reducing deficient practices of F-tags F240, 241, 242, 243, and 244.

3) A discussion of "best practices" in caring for residents with Alzheimer's disease and other dementias. "Best practices" are successful programs and practices implemented by health care provid-

ers to reduce practices and ensure the quality of life and care for health facility residents. Each course will include a best practices section for that specific topic.

Facilities may use a vendor of their choice to meet the training requirements. However, the Alzheimer's Association will be providing the ADCSCU Director Training followed immediately by the Direct Care Worker Training in order for a director to meet the twelve-hour training requirement. In addition, this will give the director the background necessary should the ADCSCU director decide to present the "Direct Care Worker Training" to his or her own staff. Directors will have access to the materials through the ISDH web site. An announcement with specific website information will follow later.

For additional information, contact the Alzheimer's Association, or the ISDH, Division of Long Term Care, at 317/233-7442. ▪

NEW ADDRESS...

The Indiana State Department of Health Cashier's Office has a new PO Box address for more expeditious handling of license fees. The new mailing address for all license renewal fees and fees for copies is:

Indiana State Department of Health
Cashier's Office
PO Box 7236
Indianapolis, IN 46207-7236

Compliance vs. Substantial Compliance

The Indiana State Department of Health (ISDH) has recently received some telephone calls from providers who are confused by the difference between compliance and substantial compliance.

According to the Centers for Medicare and Medicaid Services (CMS), F-tags written at the first level on the scope and severity grid, "A," "B" and "C", are considered in "substantial compliance." However, the phrase "substantial compliance" will only appear on a CMS-2567 when there is an "A" level finding. Findings at the "A" level do not require plan of correction *unless* there is a corresponding state rule that has been cited. Findings which are assigned a scope and severity level of "B" or "C" require a plan of correction, but do not require a revisit and do not keep the survey cycle open for enforcement purposes.

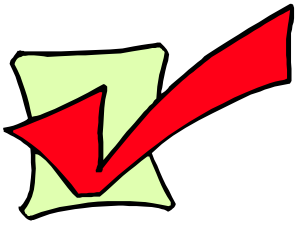
The facility is consider in "compliance" when there are no findings cited on the CMS-2567; in this case, the statement of "compliance" should be included in the initial comments on the survey report.

Questions regarding compliance vs. substantial compliance may be directed to Kim Rhoades, Survey Manager, by e-mail at krhoades@isdh.state.in.us or by telephone at 317/233-7497, or to Stephen Upchurch, Enforcement/ Provider Services Manager, by e-mail at supchurc@isdh.state.in.us or by telephone at 317/233-7613. ▪

CNA ABUSE INVESTIGATORS

The ISDH is in the process of developing protocols for the investigation of nurse aide abuse, neglect and misappropriation of resident property by specifically selected long term care surveyors. In the next two to three months, the ISDH will redirect the activities of three surveyors to investigating complaints of nurse aide abuse. Their focus will be upon the nurse aide, not the facility. ▪

Criminal History Checks



Indiana Code 16-28-13-4 states that facilities must apply within 3 business days from the date a person is employed as a nurse aide or other unlicensed employee for a copy of the person's state nurse aide registry from the state department and a limited criminal history from the Indiana central repository for criminal history information under Indiana Code 10-1-3 *or another source allowed by law*.

For many years, the ISDH has interpreted this law as requiring facilities to obtain a limited criminal history directly from the Indiana central repository only. This interpretation has now changed. "Another source allowed by law" may include any law enforcement agency. Law enforcement agencies may include local police departments, Sheriff's departments, State police departments, or, in the case of minors, even probation offices.

Screening new employees is an important component to prohibiting and preventing the abuse of a vulnerable population. Each facility should have a system in place which includes policies and procedures that describe specific steps the facility will take to ensure that the facility does not employ any nurse aide or unlicensed employee who has a disqualifying conviction. ▪

CNAs with Findings of Abuse, Neglect or Misappropriation

A report of Certified Nurse Aides with findings of abuse, neglect or misappropriation may be obtained at the ISDH web site at the following address:

www.in.gov/isdh/regsvcs/ltc/cnafind/index.htm

Reportable Unusual Occurrences

Facilities are required by law to report unusual occurrences within 24 hours of occurrence to the ISDH. 42 CFR 483.13 (c)(2) states that "the facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State Survey and Certification Agency)." Specific information related to unusual occurrences can be found in the Indiana State Department of Health's Reportable Unusual Occurrences policy and procedure dated 11/15/1997, and revised 11/20/2001.

This initial report should contain a brief description of the reportable unusual occurrence. Information should include names, especially related to abuse / neglect allegation for both resident and staff. Sizes of bruises, discoloration, skin tears, etc. should also include measurements (in numbers), description, and location. Resident elopements or leaving should also include approximate times, injuries, any previous behavior, length of time from facility and distance from facility. Also include if resident or facility have any security or alarm systems. Reportable falls should also include description of injuries, transfer or mobility status and cause of fall. When initial report is sent if origin or cause is unknown please indicate. The immediate action taken should include how incident was handled when discovered and treatment given to the resident.

The facility should send the results (follow-up) of their investigation within 5 days. The follow up should include the investigative action, plan to prevent recurrence and the method facility will use to monitor efficacy. The facility can include the follow up information on the initial report if completed. The initial report should indicate that this is the "initial and follow up" or "no follow up will be sent". Then facility will not need to send any additional information. If this is not indicated the facility will be contacted for a follow up. The follow up should include additional information as above, not just a re-statement of the initial report.

Unusual occurrence reports can be mailed, faxed or left on voice mail. It is not necessary to do all three. The information left on voice mail should be inclusive of all needed information. Follow up information can be faxed or mailed. If follow up reports are not received in a timely manner the facility will be called.

The fax/incident reporting form will soon be available from the ISDH web site www.in.gov/isdh, and is included as an insert in this issue of the LTC News. The ISDH Division of Long Term Care telephone number is 317/233-7442, the fax number is 317/233-7494, the voice mail number is 317/233-5359 and the after-hours

QMA Scope of Practice

Effective May 31, 2002, the scope of practice for Qualified Medication Aides (QMAs) was expanded to include additional tasks as follows:

1. Medical asepsis (clean technique);
2. Administration of medication via a G-Tube or J-Tube;
3. Application of a dressing to a healed G-Tube or J-Tube site;
4. Administration of medication via a metered dose inhaler;
5. Applying a dressing to a minor skin tear or minor skin condition;
6. Emptying and changing a colostomy bag, administering a Sitz bath, applying a cold dry compress;
7. Diabetic testing (urine and finger stick), collecting fecal or urine specimens, and hemoccult testing of fecal or urine specimens;
8. Pulse oximetry and oxygen saturation/application of oxygen per nasal cannula/non-sealing mask; and
9. Instilling a commercially prepared enema.

These additional topics may be taught to experienced QMAs by any registered nurse in the facility, any approved QMA instructor, or by any registered nurse contracted by the facility to provide the training.

Each QMA registered in Indiana was sent a letter April 1, 2004, instructing that the required additional training must be obtained prior to January 1, 2005 in order for the QMA to remain on the QMA Registry. Completion of the additional training is mandatory for all the QMAs practicing prior to May 31, 2002, or that were trained with the old curriculum following that date.

Even if your facility chooses not to use QMAs to perform these additional tasks, the QMAs must be trained to perform the new tasks. If QMAs do not receive the additional training and submit the appropriate state form back to the ISDH by the January 1, 2005 deadline, they will no longer be able to perform the duties of a QMA, and will be removed from the QMA Registry.

In an effort to facilitate this change, the ISDH has provided lessons 51-63 of the new QMA curriculum, and the accompanying procedures for those lessons on the ISDH web site www.in.gov/isdh. This material may be downloaded and used to update training for experienced QMAs.

Questions regarding these requirements should be directed to the ISDH Division of Long Term Care Training Director at 317/233-7480. ▪

Top 10 Deficiencies 1/1/04 thru 5/31/04

1. F324 Quality of Care
2. F281 Resident Assessment
3. F157 Notification of Rights
4. F309 Quality of Care
5. F314 Quality of Care
6. F371 Dietary Services
7. F514 Administration
8. F465 Physical Environment
9. F225 Staff Treatment of Residents
10. F323 Quality of Care
    -tie-
    F441 Infection Control

RAI Protocols

The goal of the (RAPs) is to guide the interdisciplinary team through a structured comprehensive assessment of a resident's functional status. Functional status differs from medical or clinical status in that the whole of a person's life is reviewed with the intent of assisting that person to function at his or her highest practicable level of well-being. Going through the RAI process will help staff set resident-specific objectives in order to meet the physical, mental, and psychosocial needs of the residents.

The Minimum Data Set (MDS) alone does not provide a comprehensive assessment. Rather, the MDS is used for preliminary screening to identify potential resident problems, strengths, and preferences. The RAPs are problem-oriented frameworks for additional assessment based on problem identification items (triggered conditions). They form a critical link to decisions about care planning.

The care delivery system in a facility is complex yet critical to successful resident care outcomes. It is guided by both professional standards of practice and regulatory requirements. The basis of care delivery is the process of assessment and care planning. Documentation of this process (to ensure continuity of care) is also necessary.

The RAI (MDS and RAPs) is an integral part of this process. It ensures that facility staff collects minimum, standardized assessment data for each resident at regular intervals. The main intent is to drive the development of an individualized plan of care based on the identified needs, strengths, and preferences of the resident.

It is helpful to think of the RAI as a process. The MDS identifies actual and potential problem areas. The RAPs provide further assessment of the "triggered" areas; they help staff to look for causal or confounding factors (some of which may be reversible). Use the RAPs to analyze assessment findings and then "chart your thinking."

RAPs function as a decision facilitator, which means they lead to a more thorough understanding of possible problem situations by providing educational insight and structure to the assessment process. The RAPs give the interdisciplinary team a sound basis for the development of the resident's care plan.

The RAP process includes the following steps:

-Facility staff use the RAI triggering mechanism to determine which RAP problem areas require review and additional assessment. The triggered conditions are indicated in the appropriate column on the RAP Summary Form.

-Staff assess the resident in the areas that have been triggered and are guided by The RAPs and other assessment information, including items not automatically triggered, as needed, to determine the nature of the problem and understand the causes specific to the resident.

-Staff document key findings regarding the resident's status based on the RAP review. RAP assessment documentation should generally describe:

-Nature of the condition (may include presence or lack of objective data and subjective complaints).

-Complications and risk factors that affect the staff's decision to proceed to care planning.

-Factors that must be considered in developing individualized care plan interventions. Include appropriate documentation to justify the decision to care plan for the individual resident.

-Need for referrals or further evaluation by appropriate health professionals

-Documentation about the resident's condition should support clinical decision-making regarding whether or not to proceed with a care plan for a triggered condition and the type(s) of care plan interventions that are appropriate for a particular resident.

The decision to proceed to care planning should also be indicated in the appropriate column on the RAP Summary form.

Based on the review of assessment information, the interdisciplinary team decides whether or not the triggered condition affects the resident's functional status or well-being and warrants a care plan intervention. The interdisciplinary team, in conjunction with the wishes of the resident, resident's family, and attending physician develop, revise, or continue the care plan based on this comprehensive assessment.

Ref. RAI Manual pp.4-1, 4-2, and 4-5.

For more information, you may contact the ISDH's Division of Long Term Care MDS Clinical Coordinator, Kimberly Honeycutt, by e-mail at khoneycu@isdh.state.in.us or by telephone at 317/233-4719. ▪

MDS MANUAL UPDATES

Clinicians should monitor the CMS web site at www.cms.hhs.gov/medicaid/mds20/man-form.asp for MDS Manual updates. Updates are effective the date posted on the CMS web site and are posted on the fourth Monday of each month. The most recent RAI User's Manual update is April 2004. ▪

Upcoming ISDH MDS Educational Opportunities

Event
Basic MDS Coding/ Brief Overview of MDS Reports
Dates
6/10/04 French Lick Springs Resort
6/15/04 Ivy Tech State College, South Bend
7/1/04 ISDH, Rice Aud., Indianapolis

Event
RAPs & Care Plans/ Submission & Corrections Issues
Dates
8/3/04 Ivy Tech State College, South Bend
8/12/04 ISDH, Rice Aud., Indianapolis
8/24/04 French Lick Springs Resort

Event
QI Manual/ Casper Reporting
Dates
9/8/04 ISDH, Rice Aud., Indianapolis
9/15/04 Ivy Tech State College, South Bend
9/22/04 French Lick Springs Resort

Redesign of Responsibilities at the ISDH's Division of Long Term Care

Stephen Upchurch, who has served the ISDH's Division of Long Term Care as Enforcement Manager since August 2003, has recently resumed responsibilities as the Provider Services liaison between the Division and the industry. Upchurch's new title will be Enforcement/ Provider Services Manager, and his duties now encompass both long term care enforcement and provider services areas.

This shift in responsibilities comes after the resignation of Traci Graham, who served as Program Director-Provider Services beginning in November 2003. Ms. Graham vacated the position with the ISDH in April 2004 to accept a position outside state government. Assisting Mr. Upchurch will be Jena Mendoza, BA, an experienced social worker, who has worked with Upchurch in the Division's Enforcement program since September 2003.

Mr. Upchurch and Ms, Mendoza will, continue responsibilities with the Division's Enforcement program, and will assist providers with all licensure and status changes such as bed changes, administrative staff changes, name changes, changes of ownership, and changes in provider licensure and/or certification. Mr. Upchurch may be reached by e-mail at supchurc@isdh.state.in.us or by telephone at 317/233-7613. Ms. Mendoza may be reached by e-mail at jmendoza@isdh.state.in.us or by telephone at 317/233-7794. ▪

MedQIC

MedQIC is a web-based resource created and supported by the Centers for Medicare and Medicaid Services (CMS) for the Medicare National Quality Improvement priorities.

The ISDH recommends that you visit the MedQIC web site for an information about this helpful resource:

www.medqic.org

Brief Explanation of the Centers for Medicare and Medicaid Services Revisit Policy

As Enforcement Manager for the ISDH's Division of Long Term Care, I frequently field provider questions regarding the Centers for Medicare and Medicaid Services (CMS) revisit policy. What follows is a brief explanation of the CMS revisit policy provided with the intent to help clear up some of the confusion that exists regarding revisits and substantial compliance effective dates:

First Revisit - At the first revisit, ISDH surveyors may document substantial compliance at a date earlier than the exit date of the survey, based on the facility's latest established plan of correction completion date, documentation that may be corroborated on-site at the revisit, and by on-site observations conducted at the revisit.

Second Revisit - At the second revisit in the survey cycle (not necessarily the second revisit to a particular survey), ISDH surveyors may only document substantial compliance effective the exit date of the second revisit survey unless the facility has produced to the ISDH surveyors irrefutable evidence of substantial compliance achieved earlier than the exit date of the second revisit survey. Certain deficiencies may require on-site observation to determine substantial compliance. Therefore, irrefutable evidence may not be able to be used to establish a substantial compliance effective date in certain circumstances.

Third Revisit - A third revisit may only be conducted by the ISDH with permission of CMS. In all cases, the effective date of substantial compliance for a third revisit in a survey cycle may only be the exit date of the third revisit survey. This is not negotiable.

Please also note that at revisits which are conducted in conjunction with a new complaint survey or a health survey, the correction completion dates for corrected deficiencies will be the exit date of the revisit survey if there are new deficiencies cited at that revisit survey, or at the survey done in conjunction with the revisit. In cases where a revisit to an earlier survey finds the deficiencies cited at the earlier survey to be corrected, but the new complaint or health survey conducted in conjunction with that survey finds deficiencies, the survey cycle remains open for enforcement purposes.

Questions regarding this and other enforcement matters may be addressed to Stephen Upchurch, Enforcement/ Provider Services Manager, by e-mail at supchurc@isdh.state.in.us or by telephone at 317/233-7613. ▪

For more information about the content in this publication, you may contact the Indiana State Department of Health's Division of Long Term Care at 317/233-7442.

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ADVANCE DIRECTIVES

YOUR RIGHT TO DECIDE

The purpose of this brochure is to inform you of ways that you can direct your medical care and treatment in the event that you are unable to communicate for yourself. This brochure covers:

- What is an advance directive?
- Are advance directives required?
- What happens if you do not have an advance directive?
- What are the different types of advance directives?

THE IMPORTANCE OF ADVANCE DIRECTIVES

Each time you visit your physician, you make decisions regarding your personal health care. You tell your doctor (generally referred to as a "physician") about your medical problems. Your physician makes a diagnosis and informs you about available medical treatment. You then decide what treatment to accept. That process works until you are unable to decide what treatments to accept or become unable to communicate your decisions. Diseases common to aging such as dementia or Alzheimer's disease may take away your ability to decide and communicate your health care wishes. Even young people can have strokes or accidents that may keep them from making their own health care decisions. Advance directives are a way to manage your future health care when you cannot speak for yourself.

WHAT IS AN ADVANCE DIRECTIVE?

"Advance directive" is a term that refers to your spoken and written instructions about your future medical care and treatment. By stating your health care choices in an advance directive, you help your family and physician understand your wishes about your medical care. Indiana law pays special attention to advance directives.

Advance directives are normally one or more documents that list your health care instructions. An advance directive may name a person of your choice to make health care choices for you when you cannot make the choices for yourself. If you want, you may use an advance directive to prevent certain people from making health care decisions on your behalf.

Your advance directives will not take away your right to decide your current health care. As long as you are able to decide and express your own decisions, your advance directives will not be used. This is true even under the most serious medical conditions. Your advance directive will only be used when you are unable to communicate or when your physician decides that you no longer have the mental competence to make your own choices.

ARE ADVANCE DIRECTIVES REQUIRED?

Advance directives are not required. Your physician or hospital cannot require you to make an advance directive if you do not want one. No one may discriminate against you if you do not sign one. Physicians and hospitals often encourage patients to complete advance directive documents. The purpose of the advance directive is for your physician to gain information about your health care choices so that your wishes can be followed. While completing an advance directive provides guidance to your physician in the event that you are unable to communicate for yourself, you are not required to have an advance directive.

WHAT HAPPENS IF YOU DO NOT HAVE AN ADVANCE DIRECTIVE?

If you do not have an advance directive and are unable to choose medical care or treatment, Indiana law decides who can do this for you. Indiana Code § 16-36 allows any member of your immediate family (meaning your spouse, parent, adult child, brother, or sister) or a person appointed by a court to make the choice for you. If you cannot communicate and do not have an advance directive, your physician will try to contact a member of your immediate family. Your health care choices will be made by the family member that your physician is able to contact.

WHAT TYPES OF ADVANCE DIRECTIVES ARE RECOGNIZED IN INDIANA?

- Talking directly to your physician and family
- Organ and tissue donation
- Health care representative
- Living Will Declaration or Life-Prolonging Procedures Declaration
- Psychiatric advance directives
- Out of Hospital Do Not Resuscitate Declaration and Order
- Power of Attorney

TALKING TO YOUR PHYSICIAN AND FAMILY

One of the most important things to do is to talk about your health care wishes with your physician. Your physician can follow your wishes only if he or she knows what your wishes are. You do not have to write down your health care wishes in an advance directive. By discussing your wishes with your physician, your physician will record your choices in your medical chart so that there is a record available for future reference. Your physician will follow your verbal instructions even if you do not complete a written advance directive. Solely discussing your wishes with your physician, however, does not cover all situations. Your physician may not be available when choices need to be made. Other health care providers would not have a copy of the medical records maintained by your physician and therefore would not know about any verbal instructions given by you to your physician. In addition, spoken instructions provide no written evidence and carry less weight than written instructions if there is a disagreement over your care. Writing down your health care choices in an advance directive document makes your wishes clear and may be necessary to fulfill legal requirements.

If you have written advance directives, it is important that you give a copy to your physician. He or she will keep it in your medical chart. If you are admitted to a hospital or health facility, your physician will write orders in your medical chart based on your written advance directives or your spoken instructions. For instance, if you have a fatal disease and do not want cardiopulmonary resuscitation (CPR), your physician will need to write a "do not resuscitate" (DNR) order in your chart. The order makes the hospital staff aware of your wishes. Because most people have several health care providers, you should discuss your wishes with all of your providers and give each provider a copy of your advance directives.

It is difficult to talk with family about dying or being unable to communicate. However, it is important to talk with your family about your wishes and ask them to follow your wishes. You do not always know when or where an illness or accident will occur. It is likely that your family would be the first ones called in an emergency. They are the best source of providing advance directives to a health care provider.

ORGAN AND TISSUE DONATION

Increasing the quality of life for another person is the ultimate gift. Donating your organs is a way to help others. Making your wishes concerning organ donation clear to your physician and family is an important first step. This lets them know that you wish to be an organ donor. Organ donation is controlled by the Indiana Uniform Anatomical Gift Act found at Indiana Code § 29-2-16. A person that wants to donate organs may include their choice in their will, living will, on a card, or other document. If you do not have a written document for organ donation, someone else will make the choice for you. A common method used to show that you are an organ donor is making the choice on your driver's license. When you get a new or renewed license, you can ask the license branch to mark your license showing you are an organ donor.

HEALTH CARE REPRESENTATIVE

A "health care representative" is a person you choose to receive health care information and make health care decisions for you when you cannot. To choose a health care representative, you must fill out an appointment of health care representative document that names the person you choose to act for you. Your health care representative may agree to or refuse medical care and treatments when you are unable to do so. Your representative will make these choices based on your advance directive. If you want, in certain cases and in consultation with your physician, your health care representative may decide if food, water, or respiration should be given artificially as part of your medical treatment.

Choosing a health care representative is part of the Indiana Health Care Consent Act, found at Indiana Code § 16-36-1. The advance directive naming a health care representative must be in writing, signed by you, and witnessed by another adult. Because these are serious decisions, your health care representative must make them in your best interest. Indiana courts have made it clear that decisions made for you by your health care representative should be honored.

LIVING WILL

A "living will" is a written document that puts into words your wishes in the event that you become terminally ill and unable to communicate. A living will is an advance directive that lists the specific care or treatment you want or do not want during a terminal illness. A living will often includes directions for CPR, artificial nutrition, maintenance on a respirator, and blood transfusions. The Indiana Living Will Act is found at Indiana Code § 16-36-4. This law allows you to write one of two kinds of advance directive.

Living Will Declaration: This document is used to tell your physician and family that life-prolonging treatments should not be used so that you are allowed to die naturally. Your living will does not have to prohibit all life-prolonging treatments. Your living will should list your specific choices. For example, your living will may state that you do not want to be placed on a respirator but that you want a feeding tube for nutrition. You may even specify that someone else should make the decision for you.

Life-Prolonging Procedures Declaration: This document is the opposite of a living will. You can use this document if you want all life-prolonging medical treatments used to extend your life.

Both of these documents can be canceled orally, in writing, or by destroying the declaration yourself. The cancellation takes effect only when you tell your physician. For either of these documents to be used, there must be two adult witnesses and the document must be in writing and signed by you or someone that has permission to sign your name in your presence.

PSYCHIATRIC ADVANCE DIRECTIVE

Any person may make a psychiatric advance directive if he/she has legal capacity. This written document expresses your preferences and consent to treatment measures for a specific diagnosis. The directive sets forth the care and treatment of a mental illness during periods of incapacity. This directive requires certain items in order for the directive to be valid. Indiana Code § 16-36-1.7 provides the requirements for this type of advance directive.

OUT OF HOSPITAL DO NOT RESUSCITATE DECLARATION AND ORDER

In a hospital or health facility setting, if you have a terminal condition and you do not want CPR, your physician will write a "do not resuscitate" order in your medical chart. If you are home when an emergency occurs, there is no medical chart or physician's order. For situations outside of a hospital or health facility, the "Out of Hospital Do Not Resuscitate Declaration and Order" is used to state your wishes. The Out of Hospital Do Not Resuscitate Declaration and Order is found at Indiana Code § 16-36-5. The law allows a qualified person to say they do not want CPR given if the heart or lungs stop working in a location that is not a hospital or a health facility. This declaration may override other advance directives. The declaration may be canceled by you at any time by a signed and dated writing, by destroying or canceling the document, or by communicating to health care providers at the scene the desire to cancel the order. Emergency Medical Services (EMS) may have procedures in place for marking your home so they know you have an order. You should contact your local EMS provider to find out their procedures.

POWER OF ATTORNEY

A "power of attorney" (also referred to as a "durable power of attorney") is another kind of advance directive. This document is used to grant another person say-so over your affairs. Your power of attorney document may cover financial matters, give health care authority, or both. By giving this power to another person, you give this person your power of attorney. The legal term for the person you choose is "attorney in fact." Your attorney in fact does not have to be an attorney. Your attorney in fact can be any adult you trust. Your attorney in fact is given the power to act for you only in the ways that you list in the document. The document must:

1. Name the person you want as your attorney in fact;
2. List the situations which give the attorney in fact the power to act;
3. List the powers you want to give; and
4. List the powers you do not want to give.

The person you name as your power of attorney is not required to accept the responsibility. Prior to executing a power of attorney document, you should talk with the person to ensure that he or she is willing to serve. A power of attorney document may be used to designate a health care representative. Health care powers are granted in the power of attorney document by naming your attorney in fact as your health care representative under the Health Care Consent Act or by referring to the Living Will Act. When a power of attorney document is used to name a health care representative, this person is referred to as your health care power of attorney. A health care power of attorney generally serves the same role as a health care representative in a health care representative advance directive. Including health care powers could allow your attorney in fact to:

1. Make choices about your health care;
2. Sign health care contracts for you;
3. Admit or release you from hospitals or other health facilities;
4. Look at or get copies of your medical records; and
5. Do a number of other things in your name.

The Indiana Powers of Attorney Act is found at Indiana Code § 30-5. Your power of attorney document must be in writing and signed in the presence of a notary public. You can cancel a power of attorney at any time but only by signing a written cancellation and having the cancellation delivered to your attorney in fact.

WHICH ADVANCE DIRECTIVE OR DIRECTIVES SHOULD BE USED?

The choice of advance directives depends on what you are trying to do. The advance directives listed above may be used alone or together. Although an attorney is not required, you may want to talk with one before you sign an advance directive. The laws are complex and it is always wise to talk to an attorney about questions and your legal choices. An attorney is often helpful in advising you on complex family matters and making sure that your documents are correctly done under Indiana law. An attorney may be helpful if you live in more than one

state during the year. An attorney can advise you whether advance directives completed in another state are recognized in Indiana.

CAN I CHANGE MY MIND AFTER I WRITE AN ADVANCE DIRECTIVE?

It is important to discuss your advance directives with your family and health care providers. Your health care wishes cannot be followed unless someone knows your wishes. You may change or cancel your advance directives at any time as long as you are of sound mind. If you change your mind, you need to tell your family, health care representative, power of attorney, and health care providers. You might have to cancel your decision in writing for it to become effective. Always be sure to talk directly with your physician and tell him or her your exact wishes.

ARE THERE FORMS TO HELP IN WRITING THESE DOCUMENTS?

Advance directive forms are available from many sources. Most physicians, hospitals, health facilities, or senior citizen groups can provide you with forms or refer you to a source. These groups often have the information on their web sites. You should be aware that forms may not do everything you want done. Forms may need to be changed to meet your needs. Although advance directives do not require an attorney, you may wish to consult with one before you try to write one of the more complex legal documents listed above.

WHAT SHOULD I DO WITH MY ADVANCE DIRECTIVE IF I CHOOSE TO HAVE ONE?

Make sure that your health care representative, immediate family members, physician, attorney, and other health care providers know that you have an advance directive. Be sure to tell them where it is located. You should ask your physician and other health care providers to make your advance directives part of your permanent medical chart. If you have a power of attorney, you should give a copy of your advance directives to your attorney in fact. You may wish to keep a small card in your purse or wallet that states that you have an advance directive, where it is located, and who to contact for your attorney in fact or health care representative, if you have named one.

FINAL THOUGHTS ABOUT ADVANCE DIRECTIVES

- You have the right to choose the medical care and treatment you receive. Advance directives help make sure you have a say in your future health care and treatment if you become unable to communicate.

- Even if you do not have written advance directives, it is important to make sure your physician and family are aware of your health care wishes.

- No one can discriminate against you for signing, or not signing, an advance directive. An advance directive is, however, your way to control your future medical treatment.

- This information was prepared by the Indiana State Department of Health as an overview of advance directives. The Indiana State Department of Health attorneys cannot give you legal advice concerning living wills or advance directives. You should talk with your personal lawyer or representative for advice and assistance in this matter.

Indiana State Department of Health
2 North Meridian Street
Indianapolis, Indiana 46204
http://www.in.gov/isdh

DAVE Tip Sheet

Section G, Self-Performance **March 2004**

Consistency Check Tips:

MDS Items:
G1bA – Transfers/Self-Performance
G1aA – Bed Mobility/Self-Performance
G1iA – Toilet Use/Self-Performance
G1dA – Walk-in Room/Self-Performance
G1aB – Bed Mobility/Support

Common Reasons for Inconsistencies:
- Not Using 7-day look-back period
- Contradictions within the various disciplines documentation
- Lack of documentation

Reference Source: RAI Manual, Version 2.0 December 2002, pages 3–76

Assessment Guidelines

The scales in items **G1A** and **G1B** are used to record the resident's actual level of involvement in self-care and the type and amount of support actually received during the last 7 days.

Do not record your assessment of the resident's capability for involvement in self-care — i.e., what you believe the resident might do for himself or herself based on demonstrated skills or physical attributes. For nursing facilities, an assessment of potential capability is covered in Item **G8** (ADL Functional Rehabilitation Potential).

Do not record the type and level of assistance that the resident *should* be receiving according to the written plan of care. The type and level of assistance actually provided might be quite different from what is indicated in the plan. Record what is actually happening.

Engage direct-care staff, from all shifts, who have cared for the resident over the last 7 days, in discussions regarding the resident's ADL functional performance. Remind staff that the focus is on the last 7 days only. To clarify your own understanding and observations about each ADL activity (bed mobility, locomotion, transfer, etc.), ask probing questions, beginning with the general and proceeding to the more specific.

The Data Assessment and Verification (DAVE) Project
Centers for Medicare & Medicaid Services (CMS)
www.cms.gov
Computer Sciences Corporation, www.csc.com
DAVE toll free number: 1-800-561-9812
DAVE e-mail: dave-project@csc.com

If the MDS Item Shows	Then Cross-Check this MDS Item
If B5e (Periods of lethargy) or B5f (Mental function varies over the course of the day) is present	Then **G8d** (Difference in ADL self-performance or ADL support, comparing mornings to evenings) and/or **J5a** (conditions/diseases make resident's cognitive, ADL mood or behavior patterns unstable — fluctuating, precarious, or deteriorating) should be reviewed.
If G7 (Task segmentation) is coded 1	Then **C6** (Ability to understand) should be coded **0, 1, or 2** and **should not be coded a 3.**
If G5a (Modes of locomotion – cane/walker/crutch) is checked	Then determine if **G6e** (Transfer aid) could be checked.
If G4b & cAB>0 (Functional limitation in arm & hand that interfered with daily function or placed resident at risk of injury)	Then **G1gA** (dressing) and **G1jA** (personal hygiene) should be reviewed to determine if resident requires assistance with these ADLs.
If G4b, c, d, e A is coded 1 or 2 (Functional limitation in ROM)	Then **P3a, b** (Nursing restorative — active/passive) should be reviewed to see if resident could benefit from a restorative nursing program. Also review **G3** for correct coding.
If G6a is checked (Bedfast all or most of the time)	Then **G1d,e, and f** (Walk in corridor; Locomotion on unit; and Locomotion off unit) may be coded as **8** (Did not occur)
If I1n is checked (Missing limb)	Then **G4a–f A/B** (Functional Limitation in ROM) **should not be coded 0** (No limitation/No loss).
If J1n is checked (Unsteady gait)	Then **G3a** (Test for Balance) is **possibly not 0** (Balance while standing is maintained without difficulty).

The DAVE Bulletin

Technical Assistance to Improve MDS Accuracy

Volume 1, Issue 1 March 2004

Inside this Issue:

Attachments:

DAVE Program Expands to National Scope

Welcome to the first issue of *The Data Assessment and Verification (DAVE) Bulletin*. The Centers for Medicare & Medicaid Services (CMS) is pleased to announce that the DAVE Project has expanded to a full national scope for Minimum Data Set (MDS) data operations.

Computer Sciences Corporation (CSC) is the prime contractor for this program. Under this contract, a Program Safeguard Contract Task Order, CMS has authorized CSC to conduct audits of MDS assessments, claims, and supporting documentation for long-term care and skilled nursing facilities participating in the Medicare and/or Medicaid programs. In addition, CSC will provide recommendations to CMS for improving the accuracy of the MDS data and addressing provider educational needs.

The objective of the DAVE Project is to assess the accuracy and reliability of assessment data submitted by long-term care and skilled nursing facilities. The project is also intended to support improvements in the quality of care, support CMS's program integrity initiatives to improve payment accuracy, and support payment policy development.

The DAVE Project supports CMS's efforts to establish a centralized process for measuring and improving the accuracy and reliability of the provider-submitted MDS assessment data. The findings of this process are expected to support other national, regional, and state initiatives designed to address concerns in the areas of program integrity, beneficiary health and safety, and quality improvement. The DAVE Project is also intended to provide CMS, Fiscal Intermediaries (FIs), State Agencies (SAs), and Quality Improvement Organizations (QIOs) with coordinated and directed approaches to national provider educational activities. In the future, CMS expects to replicate this process for the data collected by Home Health Agencies (HHAs).

CMS's goals for DAVE include improving the effectiveness of all the activities that make use of the assessment data. That is, DAVE hopes to improve the accuracy of the data itself, the skills of the nurses and other clinicians who perform the assessments and fill out the instruments, the accuracy of the Medicare payments derived from the data, and the accuracy and effectiveness of the review conducted of the data. CMS and the DAVE Team hope the owners of all these processes will benefit from this activity.

If you have any questions regarding the DAVE Project, please call the DAVE toll free number 1.800.561.9812 or send an e-mail to dave-project@csc.com.

Meeting the Objectives

To prepare for implementation of a national program, DAVE reviewed approximately 11,000 assessments from over 700 facilities, including 127 onsite visits. The national process incorporates valuable lessons learned from this work. This initial phase allowed the DAVE Team to test, refine, and implement a multitude of processes to meet the objectives of the DAVE Project. The processes supported CMS program areas, such as payment

For Your Information …

During national operations, the DAVE Team will use a comprehensive selection methodology that includes a random sample of facilities, stays, and assessments. This ensures a consistent process across all states, and allows the team to compute national discrepancy rates for MDS items.

During national operations, selected facilities for **onsite** *reviews can expect the DAVE Team to conduct two types of reviews.*

In the first type, the **Two-Staged Verification** *protocol, a DAVE Clinician evaluates (re-assesses) a resident who was recently assessed by the facility. This protocol also includes a reconciliation process with facility staff, during which the DAVE Clinicians discuss any discrepancies between the facility's assessment entries and the DAVE review results. During the developmental phase, this dialogue was well received by the facilities and served as an educational process to help to clarify assessment policies.*

In the other type of review process, called **Retrospective Medical Review (RMRR)***, a DAVE Clinician will determine if the assessments completed by the facility are supported by documentation in the medical record.*

Most onsite reviews take approximately three days and are conducted by two DAVE clinicians, both registered nurses.

During national operations, ***offsite*** *reviews will be conducted using the* ***Retrospective Medical Record Review (RMRR)*** *process.*

policies and refinements, quality oversight and improvement, and program integrity.

The first step of the DAVE process during the developmental phase involved selecting Skilled Nursing Facilities (SNFs) and specific MDS Assessments for clinical review. The selections were based on statistical analysis of assessment data and Medicare claims information. Records were also selected for review on a random basis to support determination of national discrepancy rates.

Clinical reviews began in June 2002 with a 6-month review period in two states (Indiana and Georgia). In November 2002, CMS extended the review process to four additional states: Florida, Pennsylvania, Texas, and Washington. Between January and September 2003, the DAVE Team evaluated the review results and refined its analytic, clinical, and communication processes as a result of its experience in the six states.

DAVE Analytic Protocols

During the developmental phase, the DAVE Team analyzed MDS assessment data using a technique called *Change in Status* protocol. This compared pairs of consecutive MDS assessments for the same resident where the facility's data suggested that the assessment information might be inaccurate. Similarly, initial data analysis of Medicare claims data focused on groups of higher-paying Resource Utilization Group (RUG) categories and other patterns that warranted further review of provider records.

Also during the developmental phase, the team designed and tested additional targeting mechanisms to identify assessments requiring further review.

In most instances, the data analysis led to a request that the provider submit copies of medical records for offsite review. Medical record requests for this type of offsite review were associated with a specific stay in a Skilled Nursing Facility (SNF). The DAVE Team also selected SNFs for onsite review, both on a random basis and as a result of analytic protocols.

MDS National Kickoff Teleconference Held

The MDS National Kickoff Industry Teleconference was held on December 11, 2003. The transcript for this call is available on the DAVE Website.

Key members from CMS and CSC reviewed the DAVE activities to date, current efforts during the national implementation, and future activities.

Thomas Hamilton, Director of the Survey and Certification Group at CMS, was enthusiastic about the DAVE Project. "With national implementation, we will have an MDS review process that, first, is national in scope; second, is very accurate in its findings, so that the results will be both correct and consistent; third, will enable us to look at national discrepancy rates; and fourth, will generate information about MDS review and error rates, with the statistical confidence that allows us to make policy decisions and to sharpen our medical review and survey processes. We expect to get useful information that will improve quality, improve payment, and improve survey and certification."

Angela Brice-Smith, Acting Director of the Program Integrity Group, in the Office of Financial Management at CMS, is pleased that "DAVE has designed and tested a comprehensive approach that meets all of our varying CMS program needs, whether that be quality reporting for consumers, payment policy development, state survey agency work, and program integrity activities." She also believes that through the national implementation, "together we can improve the accuracy of the assessment data, the quality of care in nursing homes, and ensure that Medicare payment for these services is appropriate."

CMS and CSC are eagerly anticipating the national implementation. "We're going to continue to work on these analytic protocols that we have developed, implement our education programs, and try to really disseminate the information that

Section G, ADL Self-Performance

The levels are divided into six categories:

- ***Independent** — No help or staff oversight. -OR- Staff help/oversight provided only one or two times during the last 7 days.*
- ***Supervision** — Oversight, encouragement, or cueing provided three or more times during the last 7 day. -OR- Supervision (three or more times) plus physical assistance provided, but only one or two times during the last 7 days.*
- ***Limited Assistance** — Resident highly involved in activity, received physical help in guided maneuvering of limbs or other non-weight-bearing assistance three or more times. -OR- More help provided only one or two times during the last 7 days.*
- ***Extensive Assistance** — Although resident performed part of activity, over last 7-day period, help of the following type(s) was provided three or more times:*
  - *Weight bearing support*
  - *Full staff performance during part (but not all) of last 7 days*
- ***Total Dependence** — Full staff performance of activity during entire 7-day period. There is complete non-participation by the resident in all aspects of the ADL definition task. If staff performed an activity for the resident during the entire observation period, but the resident performed part of the activity himself/herself, it would not be coded as a "4" (Total Dependence).*
- ***Activity Did Not Occur During Entire 7-day Period** — Over the last 7 days, the ADL activity was not performed by the resident or staff. In other words, the particular activity did not occur at all.*

RAI Manual, Version 2.0, December 2002

we have learned about our data trends," according to Judith Olshin, MDS National Operations Manager for CSC.

DAVE Results Translated Into Educational Activities

Training materials will be developed on the MDS items that the DAVE Team found to have the greatest potential for discrepancies. Utilization of analytic protocols, and onsite and offsite review results are vital in identifying the most frequently observed MDS item discrepancies.

Analysis of pre-national findings revealed that the majority of MDS items rarely or never show discrepancies. This is good news because it allows targeted and focused education efforts to help providers improve the accuracy of their assessments. Not only has this analysis provided the foundation for the first DAVE educational materials, it has also allowed the DAVE Team to focus their training activities to improve efficiency and effectiveness.

Finally, the DAVE Project intends to develop broader educational efforts to meet other educational needs. Some of the things being considered are satellite broadcasts, Web-posted FAQs and materials, Tip Sheets, QIES distributed materials, teleconferences, and Web conferences.

"Top 5" Highest Discrepancy MDS Sections Identified

The results of the pre-national activities showed that the most common discrepancies were found in five major MDS areas:

- **Section G —** Physical Functioning and Structural Problems
- **Section I —** Disease Diagnoses
- **Section J —** Health Conditions
- **Section O —** Medications
- **Section P —** Special Treatments and Procedures

The DAVE Project will highlight each of these areas in a DAVE Tip Sheet. The Tip Sheets represent the DAVE Project's first broad audience educational product and they are meant to share lessons learned as a result of DAVE medical review. These education materials will allow the DAVE Team to inform the entire provider and stakeholder community of the findings.

The first Tip Sheet is attached to this Bulletin and focuses on ***Section G, ADL Self-Performance***. It provides information and a set of If/then tips for Section G of the MDS. Each of the various sections of the MDS contain information that can be supported or contradicted by other areas of the MDS. Cross-checking these areas will ensure that the clinical picture of the resident is accurate. The tips can be used to check for consistency and build the foundation for reviewing the MDS form prior to submission.

As the DAVE Project proceeds through the national implementation, discrepancy statistics will continue to be captured and updates to the industry will be provided to improve the accuracy of the MDS data.

Highlights on Section G, ADL Self-Performance

The DAVE Team has found that the key to Section G is identifying what the individual actually does for himself or herself, noting when assistance is received and clarifying the types of assistance provided (verbal cueing, physical support, etc.). It is necessary to capture the total picture of the individual's Activities for Daily Living (ADL) self-performance over the 7-day look-back period, 24 hours a day across all disciplines and across all shifts.

Education News!

The following Websites have useful educational information:

Medicare Learning Network SNF PPS—Quick Reference Guide
http://cms.hhs.gov/medlearn/refsnf.asp

MDS 2.0 Technical Information Site
http://www.cms.hhs.gov/medicaid/mds20/

Centers for Medicare and Medicaid Services
http://www.cms.gov/

SNF Prospective Payment System (PPS)
http://cms.hhs.gov/providers/snfpps/

DAVE Website Provides Useful Project Information

www.cms.hhs.gov/providers/psc/dave/homepage.asp

- Project Background Information
- Various DAVE Activities
- Summary of the Beta Test
- Information on DAVE Contractors
- Transcript of National Kickoff Teleconference
- Useful Links

The Data Assessment and Verification (DAVE) Project

Centers for Medicare & Medicaid Services (CMS)
7500 Security Boulevard
Baltimore, MD 21244
www.cms.gov

Computer Sciences Corporation
3120 Lord Baltimore Drive
Baltimore, MD 21244
www.csc.com

The Delmarva Foundation
ViPS
Joint Commission Resources
The Lewin Group
Stepwise Systems

DAVE toll free number: 1.800.561.9812
DAVE email: dave-project@csc.com

FAX/ INCIDENT REPORT

State Form (6-04)
Indiana State Department of Health-Division of Long Term Care

Facility Name		
Facility Address		
City	State	Zip
Reported By	Title	
Incident Date	Incident Time	

Residents Involved

Resident Name	Room #	Age
Diagnoses		

Resident Name	Room #	Age
Diagnoses		

Staff Involved

Name	Title

Brief Description of Incident

_____

_____

_____

_____

_____

****** Please answer all questions on the second page ******

Brief Description of Incident (cont'd)

_____

_____

_____

_____

_____

_____

Type of Injury/Injuries

_____

_____

_____

_____

Immediate Action Taken

_____

_____

_____

_____

Preventative Measures Taken

_____

_____

_____

_____

Please Check One of the Appropriate Reports

☐ Initial Report

☐ Follow-Up Report

☐ Initial with Follow-Up

Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type.~~
Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.
Conflict reconciliation: Text in a statute in *this style type* or ~~*this* style type~~ reconciles conflicts between statutes enacted by the 2003 Regular Session of the General Assembly.

HOUSE ENROLLED ACT No. 1251

AN ACT concerning prescription drugs.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 16−28−11−4 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2004]: **Sec. 4. A health facility that possesses unused medication that meets the requirements of IC 25−26−13−25(i)(1) through IC 25−26−13−25(i)(6):**

(1) shall return medication that belonged to a Medicaid recipient; and

(2) may return other unused medication;

to the pharmacy that dispensed the medication.

SECTION 2. IC 25−26−13−25, AS AMENDED BY P.L.182−2003, SECTION 4, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2004]: Sec. 25. (a) All original prescriptions, whether in written or electronic format, shall be numbered and maintained in numerical and chronological order, or in a manner approved by the board and accessible for at least two (2) years in the pharmacy. A prescription transmitted from a practitioner by means of communication other than writing must immediately be reduced to writing or recorded in an electronic format by the pharmacist. The files shall be open for inspection to any member of the board or its duly

authorized agent or representative.

(b) Except as provided in subsection (c), ~~before the expiration of subsection (c) on June 30, 2003,~~ a prescription for any drug, the label of which bears either the legend, "Caution: Federal law prohibits dispensing without prescription" or "Rx Only", may not be refilled without written or oral authorization of a licensed practitioner.

(c) A prescription for any drug, the label of which bears either the legend, "Caution: Federal law prohibits dispensing without prescription" or "Rx Only", may be refilled by a pharmacist one (1) time without the written or oral authorization of a licensed practitioner if all of the following conditions are met:

(1) The pharmacist has made every reasonable effort to contact the original prescribing practitioner or the practitioner's designee for consultation and authorization of the prescription refill.

(2) The pharmacist believes that, under the circumstances, failure to provide a refill would be seriously detrimental to the patient's health.

(3) The original prescription authorized a refill but a refill would otherwise be invalid for either of the following reasons:

(A) All of the authorized refills have been dispensed.

(B) The prescription has expired under subsection (f).

(4) The prescription for which the patient requests the refill was:

(A) originally filled at the pharmacy where the request for a refill is received and the prescription has not been transferred for refills to another pharmacy at any time; or

(B) filled at or transferred to another location of the same pharmacy or its affiliate owned by the same parent corporation if the pharmacy filling the prescription has full access to prescription and patient profile information that is simultaneously and continuously updated on the parent corporation's information system.

(5) The drug is prescribed for continuous and uninterrupted use and the pharmacist determines that the drug is being taken properly in accordance with IC 25−26−16.

(6) The pharmacist shall document the following information regarding the refill:

(A) The information required for any refill dispensed under subsection (d).

(B) The dates and times that the pharmacist attempted to contact the prescribing practitioner or the practitioner's

designee for consultation and authorization of the prescription refill.

(C) The fact that the pharmacist dispensed the refill without the authorization of a licensed practitioner.

(7) The pharmacist notifies the original prescribing practitioner of the refill and the reason for the refill by the practitioner's next business day after the refill has been made by the pharmacist.

(8) Any pharmacist initiated refill under this subsection may not be for more than the minimum amount necessary to supply the patient through the prescribing practitioner's next business day. However, a pharmacist may dispense a drug in an amount greater than the minimum amount necessary to supply the patient through the prescribing practitioner's next business day if:

(A) the drug is packaged in a form that requires the pharmacist to dispense the drug in a quantity greater than the minimum amount necessary to supply the patient through the prescribing practitioner's next business day; or

(B) the pharmacist documents in the patient's record the amount of the drug dispensed and a compelling reason for dispensing the drug in a quantity greater than the minimum amount necessary to supply the patient through the prescribing practitioner's next business day.

(9) Not more than one (1) pharmacist initiated refill is dispensed under this subsection for a single prescription.

(10) The drug prescribed is not a controlled substance.

A pharmacist may not refill a prescription under this subsection if the practitioner has designated on the prescription form the words "No Emergency Refill".

(d) When refilling a prescription, the refill record shall include:

(1) the date of the refill;

(2) the quantity dispensed if other than the original quantity; and

(3) the dispenser's identity on:

(A) the original prescription form; or

(B) another board approved, uniformly maintained, readily retrievable record.

(e) The original prescription form or the other board approved record described in subsection (d) must indicate by the number of the original prescription the following information:

(1) The name and dosage form of the drug.

(2) The date of each refill.

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(3) The quantity dispensed.

(4) The identity of the pharmacist who dispensed the refill.

(5) The total number of refills for that prescription.

(f) A prescription is valid for not more than one (1) year after the original date of issue.

(g) A pharmacist may not knowingly dispense a prescription after the demise of the practitioner, unless in the pharmacist's professional judgment it is in the best interest of the patient's health.

(h) A pharmacist may not knowingly dispense a prescription after the demise of the patient.

(i) A pharmacist or a pharmacy shall not resell, reuse, or redistribute a medication that is returned to the pharmacy after being dispensed unless the medication:

(1) was dispensed to a patient:

(A) residing in an institutional facility (as defined in ~~856 IAC 1−28−1(a));~~ **856 IAC 1−28.1−1(6)); or**

(B) in a hospice program under IC 16−25;

(2) was properly stored and securely maintained according to sound pharmacy practices;

(3) is returned unopened and:

(A) was dispensed in the manufacturer's original:

(i) bulk, multiple dose container with an unbroken tamper resistant seal; or

(ii) unit dose package; or

(B) was packaged by the dispensing pharmacy in a:

(i) multiple dose blister container; or

(ii) unit dose package;

(4) was dispensed by the same pharmacy as the pharmacy accepting the return;

(5) is not expired; and

(6) is not a controlled substance (as defined in IC 35−48−1−9), unless the pharmacy holds a Type II permit (as described in ~~IC 25−26−13−17).~~ **section 17 of this chapter).**

(j) A pharmacist may use the pharmacist's professional judgment as to whether to accept medication for return under ~~subsection (i).~~ **this section.**

(k) A pharmacist who violates subsection (c) commits a Class A infraction.

SECTION 3. IC 25−26−16.5 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE

JULY 1, 2004]:

Chapter 16.5. Drug Regimens in Health Facilities

Sec. 1. This chapter applies to a health facility licensed under IC 16−28.

Sec. 2. (a) As used in this chapter, "attending physician" means a physician licensed under IC 25−22.5 who is responsible for the ongoing health care of an individual who resides in a health facility.

(b) The medical director of a health facility to which the individual is admitted may not serve as the individual's attending physician unless the medical director meets the requirements set forth in subsection (a).

Sec. 3. As used in this chapter, "protocol" means a policy, procedure, or protocol of a health facility concerning the adjustment of a patient's drug regimen as allowed under this chapter by a pharmacist licensed under this article.

Sec. 4. As used in this chapter, "therapeutic alternative" means a drug product that:

(1) has a different chemical structure from;

(2) is of the same pharmacological or therapeutic class as; and

(3) usually can be expected to have similar therapeutic effects and adverse reaction profiles when administered to patients in therapeutically equivalent doses as;

another drug.

Sec. 5. For purposes of this chapter, a pharmacist adjusts a drug regimen if the pharmacist:

(1) changes the duration of treatment for a current drug therapy;

(2) adjusts a drug's strength, dosage form, frequency of administration, or route of administration;

(3) discontinues the use of a drug; or

(4) adds a drug to the treatment regimen.

Sec. 6. At the time an individual is admitted to a health facility that has adopted a protocol under this chapter, the individual's attending physician shall signify in writing in the form and manner prescribed by the health facility whether the protocol applies in the care and treatment of the individual.

Sec. 7. (a) A pharmacist may adjust the drug therapy regimen of the individual under:

(1) the written authorization of the individual's attending physician under section 6 of this chapter;

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(2) the health facility's protocols; and

(3) this chapter.

(b) The pharmacist shall review the appropriate medical records of the individual to determine whether the attending physician has authorized the use of a specific protocol before the pharmacist adjusts the individual's drug therapy regimen.

(c) Notwithstanding subsection (a), if a protocol involves parenteral nutrition of the patient, the pharmacist

shall communicate with the attending physician to receive approval to begin the protocol. The pharmacist shall document the authorization of the attending physician to use the protocol immediately in the individual's medical record.

Sec. 8. If a health facility elects to implement, revise, or renew a protocol under this chapter, the health facility shall establish a drug regimen review committee consisting of:

(1) the health facility's medical director;

(2) the health facility's director of nursing; and

(3) a consulting pharmacist licensed under this article;

for the implementation, revision, or renewal of a protocol.

Sec. 9. Except for the addition or deletion of authorized physicians and pharmacists, a modification to a written protocol requires the initiation of a new protocol.

Sec. 10. (a) A protocol of a health facility developed under this chapter must be:

(1) based on clinical considerations; and

(2) reviewed by the health facility's drug regimen committee at least quarterly.

(b) A protocol of a health facility developed under this chapter may not:

(1) prohibit the attending physician from approving only specific parts of a protocol; or

(2) provide for an adjustment to an individual's drug regimen for the sole purpose of achieving a higher reimbursement for the substituted drug therapy than what would have been received for the original drug therapy ordered by the attending physician.

Sec. 11. A protocol developed under this chapter must include the following:

(1) The identification of:

(A) the individual whose drug regimen may be adjusted;

(B) the attending physician who is delegating the authority

to adjust an individual's drug regimen; and

(C) the pharmacist who is authorized to adjust the individual's drug regimen.

(2) The attending physician's diagnosis of the individual's:

(A) condition; or

(B) disease state;

whose drug regimen may be adjusted.

(3) A statement regarding:

(A) the types and:

(i) categories; or

(ii) therapeutic classifications;

of medication, including the specific therapeutic alternatives that may be substituted for a drug prescribed by a physician;

(B) the minimum and maximum dosage levels within the types and:

(i) categories; or

(ii) therapeutic classifications;

of medications described in clause (A);

(C) the dosage forms;

(D) the frequency of administration;

(E) the route of administration;

(F) the duration of the administration of the drug regimen and any adjustment to the drug regimen; and

(G) exceptions to the application of the drug regimen or the adjustment to the drug regimen;

for which the pharmacist may adjust the individual's drug regimen.

(4) A requirement that:

(A) the individual's medical records be available to both the individual's attending physician and the pharmacist; and

(B) the procedures performed by the pharmacist relate to a disease or condition for which the patient has been under the attending physician's medical care.

Sec. 12. A protocol developed under this chapter that is implemented for a Medicaid recipient must comply with any statutes, regulations, and procedures under the state Medicaid program relating to the preferred drug list established under IC 12−15−35−28.

Sec. 13. If a protocol developed under this chapter allows a pharmacist to substitute a therapeutic alternative for the drug prescribed by the individual's attending physician, the attending physician's authorization of the substitution is valid only for the duration of the prescription or drug order.

Sec. 14. This chapter does not allow a pharmacist to substitute a therapeutic alternative for the drug prescribed by the individual's attending physician unless the substitution is authorized by the attending physician under a valid protocol under this chapter.

Sec. 15. The individual's attending physician:

(1) shall review a protocol approved and implemented for a patient of the physician at the physician's next visit to the health facility, and at each subsequent visit of the physician to the health facility; and

(2) may at any time modify or cancel a protocol by entering the modification or cancellation in the individual's medical record.

Sec. 16. (a) Documentation of protocols must be maintained in a current, consistent, and readily retrievable manner.

(b) After making an adjustment to an individual's drug regimen, the pharmacist shall immediately document the adjustment in the patient's medical record.

(c) The pharmacist shall notify the individual's attending physician of an adjustment at least one (1) business day before the adjustment is made.

Sec. 17. (a) This chapter does not modify the requirements of other statutes relating to the confidentiality of medical records.

(b) This chapter does not make any other licensed health care provider or pharmaceutical manufacturer liable for the actions of a pharmacist carried out under this section.

(c) A physician who approves the use of a protocol under this chapter and a pharmacist who adjusts a drug regimen of a patient pursuant to a protocol under this chapter do not violate IC 25−22.5−1−2(d).

Sec. 18. A pharmacist who violates this chapter is subject to discipline under IC 25−1−9.

SECTION 4. IC 25−26−20 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2004]:

Chapter 20. Regional Drug Repository Program

Sec. 1. The definitions in IC 25−26−13−2 apply throughout this chapter.

Sec. 2. As used in this chapter, "nonprofit health clinic" means any of the following:

(1) A federally qualified health center (as defined in 42 U.S.C. 1396d(l)(2)(B)).

(2) A rural health clinic (as defined in 42 U.S.C. 1396d(l)(1)).

(3) A nonprofit health clinic that provides medical care to patients who are indigent, uninsured, or underinsured.

Sec. 3. (a) The board may organize a voluntary regional drug repository program to collect and redistribute drugs to nonprofit health clinics.

(b) The board may enter into a voluntary agreement with any of the following to serve as a regional drug repository:

(1) A pharmacist or pharmacy.

(2) A wholesale drug distributor.

(3) A hospital licensed under IC 16−21.

(4) A health care facility (as defined in IC 16−18−2−161).

(5) A nonprofit health clinic.

(c) A regional drug repository may not receive compensation for participation in the program.

Sec. 4. (a) Except as provided in subsections (b) and (c), unadulterated drugs that meet the requirements set forth in IC 25−26−13−25(i) may be donated without a prescription or drug order to the regional drug repository program by the following:

(1) A pharmacist or pharmacy.

(2) A wholesale drug distributor.

(3) A hospital licensed under IC 16−21.

(4) A health care facility (as defined in IC 16−18−2−161).

(5) A hospice.

(6) A practitioner.

(b) An unadulterated drug that:

(1) was returned under IC 25−26−13−25; and

(2) was prescribed for a Medicaid recipient;

may not be donated under this section unless the Medicaid program has been credited for the product cost of the drug as provided in policies under the Medicaid program.

(c) A controlled drug may not be donated under this section.

Sec. 5. (a) A drug that is given by a regional drug repository to a nonprofit health clinic may not be:

(1) sold; or

(2) given to a patient, except upon a practitioner's

prescription or drug order.

(b) An individual who is eligible to participate in:

(1) the state Medicaid program under IC 12−15; or

(2) a program that:

(A) provides a prescription drug benefit; and

(B) is funded in whole or in part by state funds;

is not eligible to receive a drug donated under the voluntary regional drug repository program organized under section 3 of this chapter.

Sec. 6. (a) The following are not subject to liability under IC 34−20−2−1:

(1) A person or entity who donates a drug to a regional drug repository program under this chapter in accordance with rules adopted by the board under section 7 of this chapter.

(2) A non−profit health clinic or practitioner who accepts or dispenses a drug under the regional drug repository program in accordance with rules adopted by the board under section 7 of this chapter.

(3) A regional drug repository that distributes a drug under the program in accordance with rules adopted by the board under section 7 of this chapter.

(b) Except in cases of negligence or willful misconduct by the manufacturer, a drug manufacturer is not subject to liability under IC 34−20−2−1 for a claim arising from a drug that is donated, accepted, or dispensed under this chapter to the user or the consumer.

Sec. 7. The board may adopt rules under IC 4−22−2 to:

(1) establish standards and procedures for accepting, storing, and dispensing drugs donated under this chapter;

(2) establish the types of drugs that may be donated; and

(3) administer this chapter.

SECTION 5. IC 34−30−2−101.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2004]: **Sec. 101.5. IC 25−26−20−6 (Concerning drugs donated to a regional drug repository program).**

SECTION 6. [EFFECTIVE JULY 1, 2004] **(a) As used in this SECTION, "office" refers to the office of Medicaid policy and planning established by IC 12−8−6−1.**

(b) Before January 1, 2005, the office shall review the process of returning unused medication under IC 25−26−13−25, as amended by this act, and the process of reimbursing the office for unused

medication of a Medicaid recipient. The office may consider in the office's review information provided by pharmacies that provide long term care pharmacy services. Beginning December 31, 2004, the office may review the process of returning unused medication when the office determines that a review is necessary.

(c) Before October 1, 2004, the office shall provide any information gathered under subsection (b) to the health finance commission established by IC 2−5−23−3. Before November 1, 2004, the health finance commission shall review the process of returning unused medication under IC 25−26−13−25, including the reimbursement to the office for the unused medication of a Medicaid recipient.

(d) This SECTION expires December 31, 2009.

SECTION 7. [EFFECTIVE UPON PASSAGE] **(a) The Indiana prescription drug advisory committee is established to:**

(1) study pharmacy benefit programs and proposals, including programs and proposals in other

states;

(2) make initial and ongoing recommendations to the governor for programs that address the pharmaceutical costs of low income senior citizens; and

(3) review and approve changes to a prescription drug program that is established or implemented under a Medicaid waiver that uses money from the Indiana prescription drug account established by IC 4−12−8−2.

(b) The committee consists of eleven (11) members appointed by the governor and four (4) legislative members. Members serving on the committee established by P.L.291−2001, SECTION 81, before its expiration on December 31, 2001, continue to serve. The term of each member expires December 31, 2006. The members of the committee appointed by the governor are as follows:

(1) A physician with a specialty in geriatrics.

(2) A pharmacist.

(3) A person with expertise in health plan administration.

(4) A representative of an area agency on aging.

(5) A consumer representative from a senior citizen advocacy organization.

(6) A person with expertise in and knowledge of the federal Medicare program.

(7) A health care economist.

(8) A person representing a pharmaceutical research and manufacturing association.

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(9) A township trustee.

(10) Two (2) other members as appointed by the governor.

The four (4) legislative members shall serve as nonvoting members. The speaker of the house of representatives and the president pro tempore of the senate shall each appoint two (2) legislative members, who may not be from the same political party, to serve on the committee.

(c) The governor shall designate a member to serve as chairperson. A vacancy with respect to a member shall be filled in the same manner as the original appointment. Each member is entitled to reimbursement for traveling expenses and other expenses actually incurred in connection with the member's duties. The expenses of the committee shall be paid from the Indiana prescription drug account established by IC 4−12−8−2. The office of the secretary of family and social services shall provide staff for the committee. The committee is a public agency for purposes of IC 5−14−1.5 and IC 5−14−3. The committee is a governing body for purposes of IC 5−14−1.5.

(d) The committee shall make program design recommendations to the governor and the office of the secretary of family and social services to coordinate the Indiana prescription drug program administered under IC 12−10−16−3 with the federal Medicare Prescription Drug and Improvement and Modernization Act of 2003, and to ensure that the program does not duplicate benefits provided under the federal law. In making recommendations, the committee shall consider the following:

(1) Eligibility criteria, including any changes in income limits.

(2) Benefit structure, including determining if the program will assume any of a program recipient's premiums or cost sharing requirements required by federal law.

(3) Cost sharing requirements, including whether the program should include a requirement for copayments or premium payments.

(4) Marketing and outreach strategies.

(5) Administrative structure and delivery systems.

(6) Evaluation.

(7) Coordination with existing private or public pharmaceutical assistance programs available to an individual in Indiana.

(e) The recommendations shall address the following:

(1) Cost effectiveness of program design.

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(2) Strategies to minimize crowd out of private insurance.

(3) Reasonable balance between maximum eligibility levels and maximum benefit levels.

(4) Feasibility of a health care subsidy program where the amount of the subsidy is based on income.

(5) Advisability of entering into contracts with health insurance companies to administer the program.

(f) The committee shall submit its recommended changes to the governor and the office of the

secretary of family and social services before:

(1) July 1, 2004, for program changes related to the Medicare discount program; and

(2) September 1, 2005, for program changes related to the part D Medicare drug benefit.

(g) This SECTION expires December 31, 2006.

SECTION 8. THE FOLLOWING ARE REPEALED [EFFECTIVE UPON PASSAGE]: P.L.106−2002, SECTION 1; P.L.107−2002, SECTION 35; P.L.224−2003, SECTION 68.

SECTION 9. **An emergency is declared for this act.**

Speaker of the House of Representatives

President of the Senate

President Pro Tempore

Approved:

Governor of the State of Indiana

HEA 1251

Figure

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Indiana State Department of Health

Division of Long Term Care Telephone Guide

Arranged alphabetically by subject (All are Area Code 317)

SUBJECT	CONTACT PERSON	EXTENSION
Administrator/DON, Facility Name/Address Changes	Melinda Massey	233-1324
Administration Manager	Darlene Jones	233-7351
Bed Change Requests (Changing/Adding Licensed Bed/Classifications)	Stephen Upchurch	233-7613
Complaints Manager	Karen Smith	233-7709
CNA Registry	Automated	233-7612
CNA Investigations	Jody Anderson	233-7002
CNA/QMA Training	David Miller	233-7615
Criminal History		233-7479
Director, Division of Long Term Care	Suzanne Hornstein	233-7289
Enforcement & Remedies	Stephen Upchurch	233-7613
Facility Data Inquiries	Sarah Roe	233-7904
FAX, Administration		233-7322
General Information (Reception Desk)		233-7442
Incidents/Unusual Occurrences	Fax	233-7494
	Voicemail	233-5359
	Other	233-7442
Informal Dispute Resolution	Susie Scott	233-7651
License/Ownership Verification Information	Jena Mendoza	233-7794
License Renewal	Jena Mendoza	233-7794
Licensed Facility Files (Review/Copies)	Darlene Jones	233-7351
Licensure & Certification Applications/Procedures (for New Facilities and Changes of Ownership)	Stephen Upchurch	233-7613
Life Safety Code	Rick Powers	233-7471
MDS/RAI Clinical Help Desk	Kimberly Honeycutt	233-4719
MDS Technical Help Desk	Technical Help Desk Staff	233-7206
Monitor Program	Debbie Beers	233-7067
Plans of Correction (POC), POC Extensions & Addenda	Area Supervisors	See Below
Plans & Specifications Approval (New Construction & Remodeling)	Dennis Ehlers	233-7588
Reporting	Tom Reed	233-7541
Rules & Regulations Questions	Debbie Beers	233-7067
Survey Manager	Kim Rhoades	233-7497
Training Manager	Sandra Marcum	2337480
Transfer/Discharge of Residents	Stephen Upchurch	233-7613
Unlicensed Homes/Facilities	Jody Anderson	233-7611
Waivers (Rule/Room Size Variance/ Nursing Services Variance)	Stephen Upchurch	233-7613
Web Site Information	Sarah Roe	233-7904
AREA SUPERVISORS		
Area 1	Judi Navarro	233-7617
Area 2	Brenda Buroker	233-7080
Area 3	Brenda Roush	233-7894
Area 4	Zetra Allen	233-7772
Area 5	Karen Powers	233-7753
Area 6	Pat Nicolaou	233-7441
Life Safety Code	Rick Powers	233-7471
ICF/MR 8A (North)	Brenda Meredith	233-7894
ICF/MR 8B (South)	Steve Corya	233-7561

Updated 6/11/2004

(Revised 05/11/04)

QMA Questions & Answers

1. Do RNs and LPNs at the practicum site have to be trained to supervise a QMA student's practicum? I heard you encourage everyone to be trained at the meeting, but now training entity is telling us it is not necessary.

Response:
Regulation does not require this. However, it is highly recommended the supervisor of the forty (40) hour practicum receive QMA Basic Curriculum Instruction Training. This will enable the supervisor to correlate the practicum with the QMA student's training.

2. What if the QMA student has problems and cannot complete the practicum on time? Can they get a waiver to take the test beyond a year?

Response:
No, unless extenuating circumstances have occurred.

3. Why does it have to be an RN who has at least 2 years experience, plus 1 year in long term care provision of service?

Response:
ISDH must ensure adequate training is provided to the QMA for the protection of the residents.

4. For vital signs, why was pain left out of the vital signs? (Lesson 1)

Response:
Pain is not vital sign. Pain is a symptom which requires an assessment. QMAs are not allowed to perform assessments.

5. How frequently does a qualified QMA instructor need to attend a QMA instructor program?

Response:
One time

6. Why was the term "isolation precautions" not transmission based precautions used?

Response:
Per review of the ISDH nurse aide curriculum, please note that the term utilized is "Isolation (Transmission Based) precautions." Thus, while the QMA curriculum did not utilize the term "transmission based" parenthetically as listed in the nurse aide curriculum, the intent was that the terms be synonymous. Please note that the content for both remain the same (i.e., Airborne precautions, Droplet precautions, and Contact precautions).

7. I am teaching a class at C-9 in Greenwood. We have the old curriculum. Will they be tested with the old test? If I include the new tasks, will they be tested on those as well?

Response:

New tests now include the new tasks. The old curriculum should not be used to train any QMAs after January 2004.

8. Professional Resources testing – where is it done?

Response:

Professional Resources schedules testing in an area near the student's location.

9. Can hand held nebulizing be performed by a QMA?

Response:

No, only metered dose inhalers are included in the QMA scope of practice.

10. If we are a current site, do we have to reapply?

Response:

Yes

11. How can a vocational site receive pass/fail results from Professional Resources? Can we call and get an answer? Would Professional Resources accept a signed release of information?

Response:

No, information is confidential to the student.

12. If they do not pass math or English test, can they go on?

Response:

No, the training entity must pre-screen applicants to determine if the applicant has the ability to read and write in English and perform the four (4) basic mathematical functions.

13. Can we add practicum sites after application sent?

Response:

Yes, by submitting appropriate forms.

14. What is the $50 for?

Response:

Cost for testing students.

15. Can we use our own tests?

Response:

Yes, but only during the training course; <u>not</u> as part of the final exam or competency evaluation.

16. Can the facility charge the QMA, if we pay and they leave?

Response:
This is not addressed in rules.

17. Would you clarify graduate nursing students who have not passed the state nursing boards but may function as a QMA? If they have taken their NCLEX, they usually have their nursing licenses' one week later. What would be the reason to take QMA?

Response:
If the graduate nursing student fails the state nursing boards, they may function as a QMA after successfully completing the QMA competency evaluation.

18. With the new QMA changes, do we need anything to pre-screen candidates other than English, math or 18 years old? In CNA program, not required to ask age.

Response:
Yes – High school diploma or GED, the individual must be a CNA on the CNA registry and complete at least 1,000 hours of documented work experience as a CNA within the last 24 months.

19. In the state hospitals they have to complete 3 months as a psych attendant, then are trained as QMA. Does the CNA 1000 hours criteria still apply? How are state hospital QMAs going to be tracked on the registry?

There will be a separate registry for psych attendant QMA.

20. When we are surveyed, is it ok if criminal history checks are in employee files in another area of the building or do they have to be in student files?

Response:
Records must be available as needed.

21. If seasoned QMAs attend training for new procedures, will those hours count?

Response:
Yes

22. Can QMAs do tube feedings?

Response:
No

23. What does the QMA do if there is a problem with the tube?

Response:
Get assistance from the licensed nurse.

24. Please clarify the steps for obtaining G-tube residual. Also, is it appropriate for the QMA to re-instill the residual aspirated from the G/J-tube?

Response:

In an effort to research the question in regard to assessing residual gastric content, (including amount to aspirate and the disposition of the gastric content aspirated), a source utilized by vocational school training for LPN students, (i.e., Fundamental Skills and Concepts in Patient Care, Barbara K. Timby, Lippincott, 7th edition, 2001) was reviewed and revealed the following:

"As a rule of thumb, the gastric residual should be no more than 100 ml, or no more than 20% of the previous hour's feeding volume."

Hence, the QMA curriculum directs the QMA to notify the licensed nurse "if there is 100 ml of residual obtained."

The source also addresses the following:

"Guidelines for checking gastric residual:
Continue aspirating until no more fluid is obtained
Rationale: Ensures accurate assessment
Measure the aspirated fluid and record the amount
Rationale: Provides objective data for evaluation
Re-instill the aspirated fluid
Rationale: Returns partially digested nutrients and electrolytes to the patient
Postpone tube feeding and report residual amounts that exceed agency guidelines or those established by the physician
Rationale: Reduces the rise of aspiration"

25. Can QMA be a witness for meds count – i.e. controlled substances?

Response:

Yes

26. Can QMA do physicians' order rewrite?

Response:

No

27. If you don't have a resident with a colostomy, how can they be in-serviced?

Response:

Colostomy care is not a required annual in-service.

28. Practicum sites and SSQC, federal bans, etc. – how does that apply?

Response:

Does not apply

29. Regarding CNA – why is mercury thermometer still being taught?

Response:
Mercury thermometers should not be used.

30. Is the QMA exam both written and skills?

Response:
Written only - The QMA competency evaluation consists of written multiple choice questions. Skills are addressed under practicum.

31. How recent should the criminal history check be?

Response:
Upon employment

32. If a QMA fails and needs review, does it have to be the approved program instructor, or can it be any RN in the facility?

Response:
The training must be provided by an R.N. based on the QMA training program. QMA rules do not require the review be conducted by an approved program instructor.

33. Can the QMA use nursing management CEUs to go toward the 6 hour recertification for the QMAs?

Response:
No, the minimum 6 hours of annual in-service education must be in the area of medication administration which shall include, but is not limited to, the following if facility policy allows the QMA to perform such functions in the facility:

(1) Medication administration via G-tube/J-tube
(2) Hemoccult testing
(3) Finger stick blood glucose testing

34. Is it a state regulation for a licensed nurse to sign off on PRN med or just good practice?

Response:
412 Indiana Administrative Code 2-1-9(a)(11)(D) requires the resident's record is co-signed by the licensed nurse who gave permission by the end of the nurse's shift or, if the nurse was on call, by the end of the nurse's next tour of duty.

35. I really wish that the QMA scope of practice would specifically state "no hanging tube feeds, no bolus feeds and no routine flushes – only GT meds and flush meds". The reason is because it is not specifically written in black & white, some nurses at our facility are saying to the QMAs – "if it is not written, you can do it".

Response:

QMAs cannot perform hanging tube feeds, bolus tube feeds or routine flushes of tube feeds. 412 Indiana Administrative Code 2-1-3(4)(s) specifies QMA training consists of administration of medications per G-tube or J-tube. QMAs are not trained in G-tube or J-tube feedings.

36. If I, as a separate entity, teach the QMA student in the classroom & lab, can they then go to a facility that they work at to do their practicum? I agree they should be monitored by myself, but do I have to do so constantly?

Response:

Yes, if an agreement is in place between the training entity and practicum site. Instructors must oversee the students' practicum experience.

37. Grade of "C" in Pharm class some IVTC has pharm in med surg. How can we document their Pharm grade if they don't have a separate Pharm course?

Response:

The student must provide documentation that he/she has completed a course which addresses pharmacological content.

38. Can QMA check med sheets for the new months – i.e. compare them to the old sheets and update per new orders?

Response:

No

39. Should QMA write in narrative notes in the resident's narrative regular chart?

Response:

Yes, QMA must document pertinent information in residents' chart.

40. How much time do you recommend for updating QMAs' currently practicing?

Response:

Based on facility policy.

41. Can the Director of Nursing of the facility be the program director?

Response:

The program instructor must be a registered nurse for a minimum of 2 years and work in long term care as a registered nurse for at least 1 year. Director of Nursing must serve as the DON full time per rule/regulation. Teaching the QMA course would be in addition to the full time DON requirement.

42. Do seasoned QMAs have to be tested by Professional Resources on lessons 51 thru 63?

Response:
No

43. Does a facility have to be an approved site to do QMA in-service?

Response:
No

44. Can facility charge for QMA classes?

Response:
Not addressed in rules.

45. Can a QMA lab setting be in a separate room, not just a resident room?

Response:
Yes

46. Does lab room have to be set up when not conducting class?

Response:
No

47. The equipment checklist for a QMA training site includes the presence of a mannequin. In that mannequins are quite expensive would other innovative ways in which to simulate an experience/task be acceptable?

Response:
No, a mannequin is required. However, they can be shared with other training sites.

48. Is there a QMA skills test for the final?

Response:
No

49. If we are going to be a new QMA program, should we have everything in place before we send application to ISDH?

Response:
Yes

50. Can instructors from Ivy Tech be allowed to teach QMA curriculum without any experience in long term care?

Response:
QMA instructors must have 1 year of paid long term care experience.

51. Regarding G-tube medication administration – you said if the pharmacy stated the medications were compatible (or had a list) that the meds could be administered together rather than one at a time, preceded and followed with a flush.

Response:
Yes, this is allowed if addressed in facility policy.

52. Is there a recommended drug reference book, such as Nursing PDR?

Response:
No, must use reference books identified by facility.

53. If you are a classroom and clinical site, can you teach the class portion for other facilities and allow the other facilities to complete their own practicum? (2-1-7, 2-1-6)

Response:
The key is that each class site lists the alternate practicum sites on the site application. Thus, if your facility is listed as the class site and other facilities are listed and have in place a practicum agreement with your class site, those facilities can conduct their own practicum following your classroom training. 412 Indiana Administrative Code 2-1-5 requirements must be met.

54. Must you be a CNA instructor to be a QMA instructor? (2-1-3)

Response:
No, the NA program and QMA program are separate entities. Thus, you must attend the necessary training to be either an NA instructor or a QMA instructor or training for both if you will be instructing both courses. The two courses are exclusive of one another.

55. In regard to 5 years of record retention, do the student records remain with the instructor or are the records maintained at the facility?

Response:
The approved training entity (e.g., facility, vocational school, etc.) will maintain the student records.

56. Can the annual in-service training required of the QMA functioning in a facility where these tasks are allowed (i.e., blood glucose readings, Hemoccult testing and g-tube/j-tube medication administration) be conducted by an LPN? (2-1-10)

Response:
There is no language in the law to direct who can provide necessary in-service training. The facility must ensure that whichever licensed individual has this responsibility is training appropriately per the curriculum and scope of practice.

57. If a facility does not intend to allow QMAs to conduct those tests in the Standard Scope of Practice, must a facility train current seasoned QMAs? (2-1-13)

Response:

The law requires that all current QMAs be trained on the additional tasks by January 2005. Facility policy may prohibit any task specified at 412 Indiana Administrative Code 2-1-9 (Scope of Practice). However, by law, the QMA must show evidence of training by January 2005 to continue to serve as a QMA.

58. Can the additional tasks that must be taught to current seasoned QMAs be taught by an LPN or must it be an RN? (2-1-13)

Response:

412 Indiana Administrative Code 2-1-13 specifies QMAs must complete supplemental training. The supplemental training should be provided by an RN.

59. Lesson #45 addresses the potential use of washing hands or potential use of alcohol gel prior to the administration of eye drops. Is there a concern with irritation of the eyes if alcohol gel is utilized in lieu of handwashing?

Response:

Per instructions on most products, the gel is to be allowed sufficient time to dry, thus should not cause irritation. However, should a facility prefer use of gloves or mandatory hand washing, this may be dictated per facility policy.

60. Mantoux testing is not listed on the QMA student file checklist. Should it be?

Response:

Those items listed on the student file checklist are items that are required to be in the student file per the QMA rule. However, once the student completes classroom training, it would be anticipated that the practicum site (i.e., facility) would mandate proof of mantoux testing prior to proceeding to allow the student to work with the residents. Thus, if the instructor would choose to add mantoux testing to the student file checklist this is certainly acceptable. However, the checklist was developed in accordance with the rule specific to enrollment criteria.

61. Currently, psychiatric hospitals have the capability to utilize psych attendants and those attendants are able to pass medication. Does the QMA rule affect the ability to continue with this program?

Response:

The QMA rule does not affect the rule that is applicable to psych attendants in psychiatric settings. Thus, practices of those specific sites will remain unchanged.

62. Lesson #52 regarding g-tube medication administration addresses milking of the tubing if the installation of the medication is sluggish. Is this not a prohibited practice?

Response:

First and foremost, please note that the instructor should teach that the medications be finely crushed as well as provided in liquid form if possible. The theory of milking the tubing would only be a gentle milking of the tubing. It is not intended that this would be an aggressive

effort; rather, a single attempt to dislodge any suction to the stomach mucosa. Thus, after having conferred with nursing schools/texts, it was not found that this was a prohibitive practice.

63. In a training session, it was stated that if a QMA student failed the test, the student would require "additional training". It was stated that the student would be required to submit proof of 20 hours of additional training. A specific amount is not addressed in the rule. Is there a specific requirement of number of additional hours? (2-1-8)

Response:
The rule does not specify a given number of additional hours of training. However, the instructor is required to evaluate the student's abilities and provide as many necessary hours of additional training as believed that the student will require. The instructor must keep in mind that the student will only have two more opportunities to pass the test. Thus, the additional training provided should be to best prepare the student to be successful. S. Marcum did state that she is requesting that facilities provide at least 20 hours, although not a regulatory requirement.

64. During the training, it was stated that if a CNA does not acquire the recommended 12 hours of annual in-service training, the CNA will be taken off the registry. Has the rule changed? Why would this be appropriate? (2-1-10)

Response:
Federal regulation specifies a CNA will lose certification if the CNA does not work and receive monetary compensation in this role at least every 24 months. (F496) This is the only regulatory guidance as to removal from the CNA Registry. In-service training for CNAs is addressed under F 497. This tag states the facility must "provide" 12 hours of in-service training and training should be geared toward the identified weaknesses of the CNA as identified on the CNA's performance review. The facility will be surveyed to ensure that the facility is evaluating the CNA's performance and providing necessary in-service training. However, the CNA will not lose certification for failure to maintain 12 hours of in-service training annually.

65. Some vocational schools reported that they are not aware whether students that have taken the classroom portion at the vocational school and proceed to complete practicums at a facility pass or fail upon testing. Is there a manner in which the testing entity can communicate the final disposition of the student to the vocational school?

Response:
Vocational schools may access the CNA/QMA Registry at the following web address: http://www.in.gov/isdh/regsvcs/acc/certhha/index.htm This is a fee service.

66. Will Professional Resources notify the QMA of areas of weakness that prompted failure in an effort to emphasize the manner in which to study/prepare for retesting?

Response:
No, information is not available.

67. The QMA is taught medication administration and necessary flushing before and after per g-tube/j-tube, however, can the QMA stop the feeding that is infusing in order to administer the meds and then restart the feeding following the administration of the meds?

Response:
Yes.

68. There is some apprehension from nursing staff to allow a QMA to perform a blood glucose reading for which sliding scale insulin will then be administered. Are there any recommendations relative to this?

Response:
Teach well with repeated return demonstrations as needed, and remember it is up to each facility to determine whether they want to utilize QMAs to perform any given task.

69. In regard to maintaining CNA certification, in the past, it has been stated that a CNA must work 8 consecutive hours within 24 months to maintain active status on the CNA Registry.

Response:
The parameter of 8 hours is found in the guidance to surveyors for Code of Federal Regulation 483.75(e)(7)/F496.

70. If a CNA works as a QMA in a long term care facility, one knows that the duties performed by the QMA are often the same duties that are required of a CNA. Thus, would 8 hours served as a QMA in a facility meet the requirement of working within the 24 month period to retain CNA status?

Response:
Yes. A QMA is first a CNA, thus, time worked as a QMA would count as hours worked as a CNA.

71. Is the process of documentation recognized as a part of the time counted during practicum?

Response:
Documentation is a step in the completion of many of the procedures completed by a QMA. Thus, the process of documentation is included in the calculating of practicum if that documentation is relative to the duties being performed in the scope of practice of the QMA.

72. It has been stated that the QMA instructor may expose students to additional medications over and above those listed in the basic curriculum. If so, will the QMA be tested on additional meds or will the test be exclusively those medications listed in the basic curriculum?

Response:
Only the medications listed in the basic curriculum will be addressed on the final test.

73. If a seasoned QMA voices refusal or does not want to learn the additional tasks, will the QMA have the ability to continue as a QMA in a long term care facility setting? (2-1-13)

Response:
The law requires that all current QMAs must receive the additional training no later than January 2005.

74. Must a facility or training entity inform ISDH when the additional tasks are taught a seasoned QMA?

Response:
All current QMAs must submit proof of this training when submitting request for certification by January 2005.

75. When must the new curriculum be utilized?

Response:
The basic QMA curriculum must be utilized for any class initiated after January 1, 2004.

76. If there is an out of state CNA that desires to enter QMA class, what must occur?

Response:
The CNA must first be recognized on the Indiana Nurse Aide Registry and meet all other applicant requirements.

77. If a facility has made an active decision not to teach the basic QMA curriculum in the future, can that site still conduct the necessary training for their seasoned QMAs to get them in compliance by January, 2005?

Response:
Yes.

78. Will seasoned QMAs who receive additional training undergo any type of testing to prove competency in the additional tasks? (2-1-13)

Response:
No. The facility and the QMA should retain record of proof of training of additional tasks. That proof may be reviewed during either a QMA training site visit or during the survey process. However, there will be no competency evaluation test by the state approved testing entity over the additional tasks for seasoned QMAs.

79. As administrative staff, should I have a seasoned QMA come to my facility and state "I have had the training" must I have to prove that training occurred?

Response:
Keep in mind that the QMA must maintain a record of additional training. Thus, administrative staff would be advised to review the record of such training in an effort to ensure that the QMA has been adequately trained.

80. If I have received the basic curriculum program instructor training, can I then teach anywhere or must I only teach at the facility at which I was employed at the time of training? (2-1-3)

Response:

Once the program instructor has received necessary training and certification, the program director can choose to teach at any site that has been approved as a QMA training site.

81. Must a facility have the equipment listed necessary of a teaching site in order to teach the additional skills to seasoned QMAs prior to January 2005?

Response:

The facility must have necessary equipment to simulate the additional skills to be taught the QMA if the "hands on" learning opportunity is not available.

82. Must a training entity have a practicum site agreement with all practicum sites in use?

Response:

Yes.

83. Should the proof of QMA in-service training be maintained by the facility or the individual QMAs?

Response:

It is the QMA's responsibility to track and maintain record of in-service hours for annual recertification.

84. Are there a minimum number of hours of training necessary for seasoned QMAs to obtain proficiency in the additional tasks? (2-1-13)

Response:

The law does not address specific number of hours of training. Thus, it is the obligation of the facility to conduct necessary training and assess the ability of the QMA prior to deeming that the QMA has adequately mastered the skill.

85. If a facility does not admit or have residents with g-tubes/j-tubes, must the QMAs receive the training for g-tube/j-tube medication administration prior to January 2005? (2-1-13)

Response:

Yes.

86. If a facility does not have on site residents with necessary means to train seasoned QMAs on the additional tasks, what is an option of the facility?

Response:

The operational standard # 2-V-E states that clinical experiences not available for the student can be simulated in a laboratory setting and the same should be denoted on the performance checklist. However, keep in mind the option of forming an agreement with an alternate site to conduct additional training necessary for your seasoned QMAs.

87. Can the QMAs complete performance checklists in the classroom/lab session or must these checklists be completed solely during the practicum?

Response:
If a particular task or experience is not available for the student to perform during the practicum, the practicum supervisor must allow the student to simulate the task in a laboratory setting. The simulated experience would then be documented on the practicum checklist.

88. For the QMA (first a CNA), it would appear that the individual must receive 18 hours of in-service training per year, 12 pertaining to the CNA and 6 pertaining to the QMA. Please clarify.

Response:
This is correct. A QMA in a comprehensive care facility is required to receive 18 hours of in-service training per year and in a residential care facility 14 hours.

89. On the practicum documentation worksheet, a "signature" is required. Does the signature consist of first initial and last name or the <u>full name</u> of the individual, including first name and last name?

Response:
First and last name are advisable to avoid confusion.

90. Are the QMA students allowed/intended to keep the training manuals after training is completed?

Response:
Yes. The student should retain a copy of the manual for future reference.

91. If an RN candidate (graduate nurse) does not pass State Boards three times, will he/she be allowed to take the QMA test? (2-1-8)

Response:
Graduate nursing students that do not pass the state nursing boards may function as a QMA after successfully completing the competency evaluation test with a passing score of eighty percent (80%). 412 IAC 2-1-8 (d)

92. Can a student nurse/student practical nurse take the QMA class without having been a CNA? (2-1-8)

Response:
Yes, nursing students who have completed pharmacology class with a grade of C or above are exempt from classroom training; however, the student is required to complete the practicum and successfully complete the competency evaluation test.

93. When will Professional Resources start using the new QMA test?

Response:
January 1, 2004.

94. Will the initial visit to approve a facility as a QMA site be announced or unannounced?

Response:
The visits will be announced, not a surprise visit.

95. The annual in-service education required includes the topics: med administration via g-tube/j-tube, hemoccult testing and fingerstick blood glucose testing. If the facility where the QMA is employed does not allow the QMA to perform these skills, is the facility still responsible for providing in-services on this information? (2-1-10)

Response:
Yes. All facilities must in-service on required inclusions regardless of whether the facility allows QMAs to perform these tasks. To be recertified, a QMA must obtain a minimum of 6 hours per calendar year of in-service education in the area of medication administration. Medication administration via G-tube/J-tube, Hemoccult testing, and finger stick blood glucose testing is required if facility policy allows the QMA to perform such functions in the facility.

96. Can any of the skills be simulated (i.e., positioning, vital signs)?

Response:
Yes. If a particular task or experience is not available for the student to perform during the practicum, the practicum supervisor must allow the student to simulate the task in a laboratory setting.

97. What is the criteria to be approved as a QMA training site? (2-1-7)

Response:
In addition to meeting 412 Indiana Administrative Code 2-1-7 criteria, the site must agree to maintain compliance with ISDH standards listed within the curriculum.

98. Is there a website available that lists active practicum sites?

Response:
No. However, training sites are available at: http://www.in.gov/isdh/regsvcs/ltc/qmatdir/index.htm

99. For what reason(s) might a facility be declined the approval or have approval removed to conduct QMA training?

Response:
If the facility fails to meet State Rules (410 Indiana Administrative Code 16.2, refuses unannounced visits from ISDH, refuses to write an acceptable plan of correction following an ISDH survey, or if there are training improprieties. (410 IAC, 2-1-6, 2-1-7)

100. Does ISDH rent mannequins for facility use?

Response:
No.

101. Will the QMA final examination given by Professional Resources reflect the information included in the new curriculum?

Response:
Yes, for students who have been trained using the new curriculum.

102. Will ISDH be adding nebulizer treatments to the QMA's scope of practice?

Response:
No, a licensed nurse or licensed respiratory therapist must conduct nebulizer treatments.

103. Does a facility have to be an approved practicum site in order to provide the annual required in-service training?

Response:
No.

104. Can we now teach the experienced QMAs the new checklists/tasks?

Response:
Yes.

105. The QMA Curriculum includes medication administration via g-tube/j-tube. Can QMAs provide the regularly scheduled water flushes via g-tube?

Response:
No. The rule indicates that QMAs can **administer medications** via G-tube or J-tube. QMAs may provide the water flush just prior to medication administration and post-medication administration, not other routinely ordered flushes.

106. Can QMAs be trained to obtain urine specimens from a Foley catheter? (2-1-9)

Response:
Yes, QMA is recommended to be trained on this procedure. The rule itself states that the QMA may "collect fecal or urine specimens as ordered by the physician." The QMA curriculum addresses collection of a routine urine specimen voided from the urethral opening/meatus. Should the physician's order read to obtain the specimen from the catheter, this would not be contradictory to the law in that the QMA may collect a urine specimen "as ordered by the physician." However, given that the QMA curriculum does not address this specific means of collecting the specimen, it would be the obligation of the facility to provide the facility policy and record of training of procedures as to the collecting of a urine specimen by means of the catheter.

107. What if the RN program instructor is uncomfortable signing the documentation of practicum hours for other practicum supervisors? What do we do in this situation?

Response:
There must be a contractual agreement between the classroom site and the practicum site. The instructor is advised to meet and be comfortable with the practicum supervisors as this is a collaborative effort.

108. Can QMAs utilize either a piston syringe or an asepto syringe when administering g-tube/ j-tube medications?

Response:
Lesson #52: Administering Medications Via the G-tube or J-tube – specifies for maximum control or suction, use a piston syringe rather than an asepto syringe. Current facility policy must be followed.

109. Can a QMA apply steri-strips to a skin tear?

Response:
Yes, the rule itself states that the QMA may "apply a dressing to a minor skin tear that has been assessed by a licensed nurse." The rule does not specify the type of dressing to be utilized. The curriculum addresses basic principles of management of the skin tear, such as "if a layer of skin is attached, replace the skin over the wound. Cover as much of the original surface as possible" and proceeds to discuss the use of a transparent dressing due to the common use of this type of dressing. Given that steri-strips may be the choice of "dressing" utilized and there is no contradiction to this type of dressing in the rule, it would be the obligation of the facility to provide the facility policy and record of training of the application of steri-strips as a means to dress a minor skin tear that has been assessed by a licensed nurse. Caution should be taken to ensure that the area to which steri-strips are being applied as a type of dressing is considered a minor skin tear and has been assessed by the licensed nurse.

110. Would ISDH survey results affect the ability of facilities to train QMAs?

Response:
It may, 412 IAC 2-1-6 (c)(1) states that ISDH may remove approval to train QMAs from an entity that does not meet requirements of 410 IAC 16.2.

111. Do all licensed nurses who intend to be practicum supervisors or assist with the practicum need to attend the ISDH QMA training session or can the RN program director who attended the session take the information back to the facility and train additional licensed nurses?

Response:
Nurses who have attended the QMA training may train other licensed nurses relative to practicum completion.

112. If a facility does not have any g-tube/j-tube residents, how do we do return demonstration?

Response:

This skill would have to be simulated.

113. It was stated at the training that a nursing student who has completed a pharmacology class with a grade of "C" or above must still have 1000 hours of experience as a CNA to be eligible to complete the practicum and sit for the test. This is different than previous ISDH policy and seems to pretty much eliminate nursing students from becoming QMAs. Is this a correct interpretation of the rules at 412 IAC 2-1-8 (e)? Or, by its placement in this Section – QMA Competency Evaluation – does it not imply that CNA training and experience are waived and the only requirement is completion of the practicum and successful completion of the competency evaluation test? What about a graduate nursing student that has not passed the State Boards as described in 412 IAC 2-1-8 (d)? Does that person also have to be a CNA with 1000 hours experience? (2-1-8)

Response:

Refer to Question/Answer #91 & #92. CNA status with 1,000 hours of documented work experience is not applicable for nursing students or graduate nursing students that do not pass state boards.

114. On page 200 of the curriculum at VII, "Responsibilities for PRN Medication Administration" at "D"(1), it states that the nurse must assess the resident to determine the need for the PRN medication. However, in the rule 412 IAC 2-1-9 (a) (11) it states that the QMA may administer the medication only if authorization is obtained from the licensed nurse on duty or *on call*. If the nurse were not on site (which is acceptable in a residential setting), personal assessment of the resident would be impossible. Should the curriculum be reworded to accommodate this situation? Also, it was my understanding that, for example, in the case of several residents who have requested sleeping medications, the QMA would be permitted to ask for authority to give meds for more than one resident without nurse assessment. Please clarify.

Response:

Assessment may be conducted by the nurse given a <u>verbal</u> report of the resident's status or a physical assessment on the basis of whether the nurse is available.

115. The form for documentation of the practicum requires signatures of each supervising nurse. At the bottom of the form there is an additional signature line for the Program Director to verify that the hours are correct and are actual times of medication and treatment administration. I believe that the signatures of the licensed health professionals should be sufficient and that the Program Director would be hesitant to sign verification when he or she was not present to verify. It seems to me that the statement could precede the signatures of the practicum supervisors and then be signed by the student as accurate.

Response:

The program instructor is required to sign the form "Documentation of QMA Practicum.

116. It was stated that the annual in-service education must include medication administration by J/G tube, Hemoccult testing and finger stick blood glucose testing, regardless of whether facility policy allows QMAs to perform those functions. The rule states at 412 IAC 2-1-10 (c)

that this is required only if the facility policy allows QMAs to perform those functions. Please clarify.

Response:
That is correct. The annual in-service education on medication administration by J/G tube, Hemoccult testing and finger stick blood glucose testing, is not *required* unless facility policy allows QMAs to perform those functions.

117. It was stated that even if a QMA verifies the required 6 hours of annual in-service for recertification as a QMA, if the QMA does not have proof of 12 hours of annual in-service as a CNA, he/she would lose their certification as QMA. I believe this is incorrect, as lack of 12 hours of in-service education does not cause a CNA to lose their certification. The facility is responsible for providing 12 hours of in-service and may receive a citation if they fail to do that for one or more CNAs, but it does not cause the CNA to lose certification. Thus ISDH would not be permitted to disqualify the QMA from recertification based on lack of proof of 12 hours of CNA in-service.

Response:
Correct.

118. Can the health care associations teach or offer the QMA course for instructors?

Response:

Yes, with written approval of ISDH, Division of Long Term Care. (Program Operational Standards 1, I, C

119. Please clarify the steps for obtaining g-tube residual. It is our facility policy that the caregiver check for residual. However, the individual is not required to withdraw the entire amount of residual rather verify that the residual is present. Please clarify.

Response:
Lesson #52, IV, L specifies: #1 if you hear this sound (bubble), gently draw back on the piston of the syringe. V, G: withhold medications if there is 100ml of residual obtained and notify the nurse.

120. Please clarify the heading on page 199 which states "assessing resident before and after...". It has been stressed that the QMA is not to assess the resident's condition. Please clarify.

Response:
This should state "obtaining indicators of resident status before and after medication administration." As the instructor reviews this section, one must note that the QMA is not requested to assess/evaluate the resident's status based on vital signs, rather follow the order/facility policy in regard to administering or withholding medication based upon the measurement of the resident's vital signs/parameters.

121. Can a QMA witness the wasting of narcotics per the physician's order? For example, if the remaining narcotic in an injectible form is being wasted by a licensed nurse, can the QMA witness the disposal/wasting of a narcotic?

Response:
Refer to facility policy.

122. Can a QMA participate in reviewing physician rewrites?

Response:
No.

123. Must a practicum supervisor co-sign every box of every medication administered by the QMA student or may the practicum supervisor co-sign the Student Medication Aide's full signature either on the bottom of the medication administration record or on a signature page.

Response:
Practicum supervisor signature is required for each entry. The printed name is necessary once per signer.

124. Will there be a performance portion of the final exam or will the final exam be written only?

Response:
Written final exam only. The checklists completed with 100% accuracy indicate performance proficiency.

125. Must there be a <u>new</u> criminal history obtained for a current employee of the facility? For example, an employee may have been with a facility for multiple years and had a criminal history obtained upon hire and has remained in good standing with the facility. In this case, must a new criminal history be obtained?

Response:
If the current employee is completing the QMA practicum in the facility of hire, the criminal history obtained at the time of employment may be used. For all other situations, a new criminal history must be obtained.

126. Is there a possibility of oral testing for those students who experience "test freeze"?

Response:
This has not yet been addressed with Professional Resources.

127. Some nursing schools have deleted the use of "SOB" serving as an abbreviation for "shortness of breath", however, this abbreviation is utilized in the basic QMA curriculum. Please clarify.

Response:

"SOB" as used in a medical context, is an acceptable abbreviation. Facility policy will delineate standard facility abbreviations.

128. Is there any guidance from ISDH as to the facility's policies in regard to missed classes or conduct which would indicate the student should not be allowed to continue in the course?

Response:
No. The training entity must develop policies/procedures to govern its own actions in regard to these issues. Class time and/or practicum must meet QMA training requirements, both hours and content.

129. If an individual is a home health aide, does this qualify as a CNA to take the QMA course?

Response:
No.

130. Units under JACHO accreditation have approved abbreviations that may differ from the QMA curriculum. In this case, what is the guidance from ISDH?

Response:
Individual facility policy will delineate the standard facility abbreviations.

131. Will any addendums to the basic curriculum be mailed to the instructor's home if the home location was listed when the instructor enrolled for the basic curriculum training?

Response:
No, any addendums to the basic curriculum will be posted to ISDH, Regulatory Services web site. Notice will be published in the LTC Newsletter.

132. If a seasoned QMA receives 6 hours of in-service to obtain the additional training, can that 6 hours be applied as the annual in-service training for the year 2004?

Response:
Yes, for 2004. For 2005 and every year thereafter, a certified QMA will be required to receive 18 hours of in-service training for comprehensive care facility and 14 hours of in-service training for residential care facility. See Rule 412 IAC 2-1-10(b)(c) – 410 IAC 16.2-3.1-14(l) – 410 IAC 16.2-5.1-4(e)(1).

133. Can a QMA instill a bolus tube feeding?

Response:
No.

<u>Recommendations</u> from Professional Resources (the testing entity):

- If a QMA class of 20 students is being taught, the instructor is encouraged to submit the students for testing at the same time just as would be done with an NA class. The instructor is also encouraged to be there for the testing. It is important to the student to have the moral support of the instructor whether the student passes or fails.
- When submitting applications, please ensure that those applications reflect the legal name of the student and not "nicknames".
- Be certain that practicum times reflect medication passes and treatment applications. No lunch times or breaks should be entered on the practicum time sheet.

Clarifications Needed by Professional Resources:

- Professional Resources will need to know how to initiate the old versus the new testing. That is, how to delineate when a student arrives whether they have been there to be tested on the old curriculum versus a new curriculum. During training, S. Marcum stated to indicate by writing "old curriculum" or "new curriculum" at the top of the testing application.
- Professional Resources will need a list of information in the QMA Curriculum that is obligatory or "not" to be included in testing. (Example: FAST Scale in Alzheimer's section.)
- The chapter with abbreviations has the abbreviations "OD, OS, OU" both in all caps and lower letters. Professional Resources would like to know <u>which</u> to use for testing purposes, caps or lower case.

ROUNDTABLE DISCUSSION QUESTIONS

MARCH 26, 2004

1. It has been reported the state Ombudsman assigned to Assisted Living has called our facilities and after introducing herself began asking several direct questions regarding the existence of a family council. But, here is the question. When the Ombudsman was asked directly if facilities were responsible for establishing a family council or were facilities required only to provide space and answer any written questions, the Ombudsman stated that the facility should be cited (after a warning) by survey teams if a family council does not exist.

The Residential regulation that applies to this question is in Resident Rights Section o. 1, 2, 3 & 4. The Comprehensive regulations are in Section 3.2. H, I, J, K & L. We understand these regulations to require the facility to provide space and privacy. Also the facility is to respond to questions and requests that may come from a family council. We do not understand that the facility is obligated to recruit, organize and maintain a family council as stated by the Assisted Living Ombudsman. Please clarify.

ANSWER: The explanation provided is correct.

410 IAC 16.2-5-1.2 (o) Residents have the right to form and participate in a resident council, and families of residents have the right to form a family council to discuss alleged grievances, facility operation, resident rights, or other problems, and to participate in the resolution of these matters as follows:

- **(1) Participation is voluntary.**
- **(2) During resident or family council meetings, privacy shall be afforded to the extent practicable, unless a member of the staff is invited by the resident council to be present.**
- **(3) The licensee shall provide space within the facility for meetings and assistance to residents or families who desire to attend meetings.**

410 IAC 16.2-3.1-3 (h)(i)(j)(k)(l)

- **(h) A resident's family has the right to meet in the facility with the families of other residents in the facility.**
- **(i) The facility must provide a resident or family group, if one exists, with private space.**
- **(j) Staff or visitors may attend meetings only at the group's invitation.**
- **(k) The facility must provide a designated staff person responsible for providing assistance and responding to written requests that result from the group meetings.**
- **(l) When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families and report back at a later time in accordance with facility policy.**

2. The new licensed residential rules require that "a minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on-site at all times". Is it the interpretation of the

ISDH that any licensed physician, RN, LPN or EMT functioning in this capacity is required, in addition to licensure or certification for their scope of practice, to hold a certificate verifying additional training in first aide?

ANSWER: Correct. See 410 IAC 16.2-5-1.4 (b) A minimum of one awake staff person, with current CPR and first aid certificates, shall be on-site at all times.

3. Some hospital-based administrators are struggling with how to handle the Notice of Transfer or Discharge form for TCU residents needing extended care, and transfer to an extended care facility. The TCU usually admits a resident who is expected to meet their rehabilitation goals in a relatively short period of time. Once it is determined the resident will continue to need rehab past their TCU stay, it becomes difficult to identify which of the reasons listed on the Notice of Transfer or Discharge is appropriate for this situation. How does the State interpret the usage of the Notice of Transfer or Discharge form in this instance? The reasons for discharge listed on the form are:

The transfer or discharge is necessary to meet the resident's welfare and the resident's needs cannot be met in the facility.
The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility.
The safety of individuals in the facility is endangered.
The health of individuals in the facility would otherwise be endangered.
The resident has failed.....to pay for services...
The facility ceases to operate.

ANSWER: If the TCU is a licensed comprehensive care facility, the transfer/discharge requirements are the same regardless of the physical location. The TCU must follow all the transfer/discharge requirements.

4. In reference to facility wound rounds, if a facility has a policy that lists the disciplines involved in the rounds and the list includes the dietary manager, is there anything that would prohibit the dietary manager from attending these rounds? What if the family and/or resident have been spoken to and have no objection to them being present?

ANSWER: There is no prohibition to the dietary manager participating in wound rounds. Facility policy will delineate the disciplines involved in the rounds. Unless permission is denied or resident objects the dietary manager may participate.

5. Are individual policies and procedures required to have a name and date on the bottom of them when they are created or when revisions are made?

ANSWER: No. See 410 IAC 16.2-3.1-13 (j) "The licensee shall approve the policy manual, and subsequent revisions, in writing. The policy manual shall be reviewed and dated at least annually ……"

6. To what extent do you see HIPAA impacting the involuntary discharge process? If a facility needs to transfer a resident but the family and/or resident do not want to be transferred, they

could refuse consent for another facility to look at the resident's clinical records. How would you advise a facility to proceed?

ANSWER: **According to CMS, HIPAA has no impact on the involuntary discharge process. The resident has a right to privacy and confidentiality of his/her clinical record and to refuse release of personal and clinical records. This right does not apply when the resident is transferred to another health care institution. See 410 IAC 16.2-3.1-3(r)(1) and 42 CFR 483.10(e)(1)(i).**

The facility where the resident currently resides can have another facility come in and evaluate the resident without either the resident's or the family's permission. Under HIPAA, there are three situations in which the HIPAA for consent does not apply in order to share medical information: treatment, payment and healthcare operations. Under treatment, that includes consultations for the purpose of coordination of care. If the facility feels they cannot provide the level of care the resident needs, then they can bring in other health care providers to evaluate what level of care the resident needs and where that level of care can best be provided.

7. A facility was visited by a nurse surveyor who stated that she was there to do an "internal auditing survey of the complaint survey process as part of a QA program." She requested facility administrative information, roster matrix, census mealtime schedule and facility layout. She toured the building and watched meal service. She stated once again that her visit was not due to a complaint but was a new process implemented recently. (10-29-03) Can you explain?

8. A facility admitted a resident who had served prison time as a sex offender. Can you advise the facility as to what the expectations of ISDH are in this regard if different than any other admission?

ANSWER: In the Indiana State Department of Health, Long Term Care closure letter to the complainant, the complainant is offered the following opportunity, "If you are dissatisfied with the results of this investigation and would like to have the investigation reviewed, please submit your request and concerns, in writing, within 30 days of receipt of this letter to: Susie Scott, R.N., Division of Long Term Care, Indiana State Department of Health, 2 North Meridian Street – Section 4B, Indianapolis, IN 46204. Once a letter is received, a thorough review of the complaint investigation paperwork will be conducted. If it is determined that the complaint survey protocol was not followed, a second investigation by a different surveyor will be conducted following complaint survey protocol. If the facility is found to be non-compliance during the 2nd investigation, state findings will be documented on the 2567.

9. Can you advise appropriate procedures for situations that are potentially "coroner's cases"? Coroner law states that the attending physician or the local health officer, in the absence of the attending physician, are to make the decision if the coroner is to be notified. If so, does the nursing home ever have a direct responsibility to notify the coroner?

ANSWER: There appears to be a conflict in the Indiana Code on the issue of coroner's cases. The Long Term Care Division has asked for clarification for the Office of Legal Affairs. In the meantime, facilities are urged to check with their county coroner's office to

determine if that office has any protocols the facility should follow when a resident has died.

10. Follow-up question from #9. If a death becomes a coroner's case, should there be a follow-up report in the patient's medical record?

ANSWER: There is no requirement in the regulations that such a report be in the resident's clinical record. The resident's clinical record is a documented history of the resident's stay in the facility. One would not expect to find information in the clinical record about the resident when the resident no longer resides in the facility.

11. Since OTC drugs are not required to be labeled by a pharmacist, is there any reason why a facility cannot obtain such OTC drugs from a non-pharmacy supplier? The facility would continue to identify each medication per state regulations.

ANSWER: No, however the OTC medications must be in the original package and identified according to:
410 IAC 16.2-3.1-25 (l) for comprehensive care facilities
410 IAC 16.2-5-6 (c)(6) for residential care facilities.

12. A surveyor investigating a complaint asked for complaint, grievance and incident logs. The administrator told her that he did not believe they were required to provide such logs. The surveyor stated that that did not apply to complaint surveys. Clarify?

ANSWER: Regardless of the type of survey being conducted, if the abuse prohibition investigative protocol is required, the surveyor needs to evaluate the facility's implementation of policies and procedures that prohibit abuse, neglect, involuntary seclusion and misappropriation of resident property. As part of the evaluation process, the surveyor needs to obtain and review the facility's abuse prohibition policies and procedures; interview appropriate staff and residents; and see written evidence of how the facility has handled alleged violations. The protocol requires the surveyor to select 2-3 incidents of allegations of abuse, etc. since the last standard survey or other review.

A facility is not required to produce complaint, grievance or incident logs. But the facility must cooperate by providing enough information so that the surveyor can select which allegations should be reviewed to determine if the facility has implemented adequate procedures for reporting and investigating; protecting the resident during the investigation; and taking corrective action.

13. A surveyor was in a nursing facility reviewing the hospice care. She requested the ADL flow charts from the nursing home records, however, the hospice was keeping those records. Is the facility expected to duplicate records that are already being kept by the hospice nursing staff?

ANSWER: Each entity is responsible for their respective regulatory requirements. The coordinated care plan will delineate the care required by the resident, including the responsible entity. While it is not required both entities document ADL care, there is no prohibition to the documentation.

14. It was reported that a surveyor cited a facility for having extra trash bags in the bottom of the trash can, ready for the next use. It was stated that this was an unacceptable practice due to infection control concerns. Is that correct?

ANSWER: No, there is no prohibition to placing extra trash bags in the bottom of a trash can.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-12-25
Baltimore, Maryland 21244-1850

Center for Medicaid and State Operations/Survey and Certification Group

Ref: S&C-04-27

DATE: **May 13, 2004**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Opening of New Centers for Medicare & Medicaid Services (CMS) Web Site Resource for Long Term Care (LTC) Surveyors and Providers

Letter Summary

- CMS announces the development of a new Web site resource for State Survey Agencies, CMS Regional Offices, and long term care providers.
- Its purpose is to provide summaries of nationally accepted clinical/professional standards and guidelines for surveyors and providers.

I am pleased to announce the development of a new resource for State Survey Agencies, CMS Regional Offices, and long term care providers. Through a contract with the American Institutes for Research (AIR), we have developed a Web site repository containing summaries of nationally accepted clinical/professional standards and guidelines that should be useful to surveyors who are evaluating facility practices to determine compliance with the long term care requirements, as well as to providers.

In 1998, CMS, in collaboration with a committee of industry, clinical, advocate, and survey agency national groups developed a CMS Web site repository titled Sharing Innovations in Quality (SIQ) for sharing both innovative practices submitted by facilities and current clinical standards/guidelines. Because of a lack of activity, the Web site was archived in 2000. Due to our need to ensure surveyors have up-to-date knowledge of good practice, we have decided to revamp the portion of the SIQ site containing clinical/professional standards and guideline summary materials.

AIR, with the help of a clinical consultant, has been tasked with searching among thousands of guidelines for those that would be most useful to long term care surveyors and providers. To facilitate the identification of relevant information for the Web site, AIR has established communication links with national organizations, federal agencies, and universities to locate nationally accepted content for the repository. The relevant content provided by these organizations is being summarized in the form of abstracts and ordering information.

We plan to add new materials to the site periodically, after evaluation by CMS staff and the contractor and permission is obtained from the sponsoring organizations. In order to assure that the site contains the most current information, the contractor will continue to access the organization sites to keep our summaries updated as newer versions of standards are released.

The new Web site is now available and includes user-friendly search and sort features to meet the needs of its anticipated users. The site address is: www.cms.hhs.gov/medicaid/survey-cert/siqhome.asp.

We hope that this information is of use to your staff. If you have suggestions or concerns, please contact Karen Schoeneman at 410-786-6855, or via email at kschoeneman@cms.hhs.govT.

Effective Date: Immediately.

Training: The information contained in this announcement should be shared with all surveyors, survey and certification staff, their managers, and the state/RO training coordinators.

/s/
Thomas E. Hamilton

cc: Survey and Certification Regional Office Management (G-5)